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ABSTRACT

This newsletter issue is about the growth of programs that serve infants, toddlers, and their families, and the management of that growth. The articles address early intervention programs with infants and young children with disabilities. The first article, "Implementing a Multi-site, Multidisciplinary Clinical Trial: The Infant Health and Development Program" (by Ruth T. Gross and Christine Hayes), describes a program combining early child development and family support services with pediatric follow-up for reducing the developmental and health problems of low birthweight, premature infants. The second article, "Empowering Parents--the Evolution, Evaluation and Expansion of a Program", by Walter Barker, describes the rationale, problems, and success of the Child Development Program covering 30 health authorities in England, Northern Ireland, Wales, and the Irish Republic. "Healthy Growth for Hawaii's 'Healthy Start': Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect" by Gail Breakey and Betsy Pratt. It describes the critical elements of the Healthy Start program and examines the processes of collaboration and advocacy that have fostered program expansion. The fourth article is "Replicating Demonstration Projects: A Beginner's Guide" (by Marilyn M. Segal and Luba Lynch) which identifies critical features of a replicable model, describes the replication process, and notes the role of the process evaluation. The last article "Managing Growth at Child Care Solutions" by Ruth Anne Foote describes principles of growth which have helped one program cope with current demands and meet new demands. (DB)

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Zero to Three

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Implementing a Multi-site, Multidisciplinary Clinical Trial: The Infant Health and Development Program

by

Ruth T. Gross and Christine Hayes

With the survival of increasing numbers of smaller and smaller premature infants, the need to study and support their health and development became apparent. The Infant Health and Development Project was an eight-site randomized clinical trial designed to evaluate the efficacy of combining early child development and family support services with pediatric follow-up in reducing the developmental and health problems of low birthweight, premature infants. The prospect of starting up and conducting such an intense, comprehensive program for nearly 1000 infants was indeed exciting. But as challenging as we found the prospect, we knew there would be problems as well—that we would be faced with difficult decisions as well as with opportunities to make mistakes. Despite the intimidations and reservations, we accepted the challenge eagerly.

In this article, we identify some of our struggles, giving special attention to those that may befall any clinical trial or program where a variety of people from different sites and diverse professional backgrounds must function as a team. We explain how we approach and resolve problems and, in some cases, how we would have handled them if given the chance to do it all over.

Design of the study

A total of 985 infants with birthweight of five and a half pounds or less and gestational age of 37 weeks or less participated in the study. The infants were

NANCY P. ALEXANDER

The Infant Health and Development Program was funded by grants from the Robert Wood Johnson Foundation to the Department of Pediatrics, Stanford University, Stanford, CA; the Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill; and the eight participating universities. Additional support for the National Study Office was provided to the Department of Pediatrics, Stanford University, from the Pew Charitable Trusts; the Bureau of Maternal and Child Health and Resources Development and the National Institute of Child Health and Human Development, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services (grant MCJ 060515); and the Stanford Center for the Study of Families, Children, and Youth.

We express our deep appreciation to Ruby P. Hearn, Ph.D., vice president of the Robert Wood Johnson Foundation, for her guidance and support throughout the study.

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randomly assigned to either an Intervention Group or a Follow-Up Group. Both groups received high-quality pediatric surveillance, which included periodic assessments of health and development, with referrals as indicated, and the acquisition of family data. The Intervention Group also received specialized child development and family support services. The latter were implemented through home visits from an early childhood education specialist, enrollment in a special child development center (CDC), and participation in parent meetings. An early childhood curriculum was developed in the home and at the child development centers. The intervention was initiated as soon as the infants went home from the nursery and was continued until they reached 36 months of age, corrected for prematurity (Wasik, 1990; Sparling, 1991; Sparling, 1984; Ramey, 1991).

The main results of the study

The children in the Intervention Group benefited from the program in several ways. Compared to the children in the Follow-Up Group, at 36 months they showed a large and highly significant difference in cognitive development—from 6 to 13 points on an IQ scale, depending upon birthweight. Stated another way, the Follow-Up children were almost three times as likely to have IQ scores in the range of mental retardation as the Intervention children. Further, the Intervention Group mothers reported significantly fewer behavior problems, particularly those that may predict later difficulties. In addition, the Intervention children had no more serious health problems than those in the Follow-Up Group, despite their participation in group care (IHDP, 1990).

A videotape describing the IHDP, available on loan for a two-week period, can be requested from the Robert Wood Johnson Foundation. Also available are three brochures: *A Summary for the Medical Profession; A Summary for Policymakers;* and *A Summary for Educators.* Up to 20 copies of each brochure may be requested from Sue Weidner, Robert Wood Johnson Foundation, College Road, P.O. Box 2316, Princeton, NJ 08543-2316.

Organization and staffing of the study

The National Study Office (NSO), located at Stanford University, served as the research coordinating and data management center for the study. The education components of the intervention and their implementation were the responsibility of the Frank Porter Graham Program Development Office (PDO) at the University of North Carolina at Chapel Hill. After the first year, a Research Steering Committee was charged with the scientific conduct of the study.

The eight participating sites, chosen by competitive review, were: the University of Arkansas for Medical Sciences; Albert Einstein College of Medicine; Harvard

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Medical School; University of Miami School of Medicine; University of Pennsylvania School of Medicine; University of Texas Health Science Center at Dallas; University of Washington School of Medicine; and Yale University School of Medicine.

At each of the eight sites the core staff consisted of:

- a site director in charge of the program (usually a developmental pediatrician or neonatologist; at one site, a child psychologist);
- an education director in charge of the education component, including supervision of the home visitors and the staff at the child development center;
- two pediatric nurses, or one nurse and one social worker, who conducted the clinical and social assessments and provided family support;
- three home visitors who made weekly home visits in the first year and biweekly thereafter;
- fifteen teachers and assistant teachers, providing a ratio of one teacher to three children ages 12 to 24 months and 1:4 for children ages 24 to 36 months;
- a study coordinator who managed the data collected on both Intervention and Follow-Up Groups, scheduled the clinic visits, and maintained interim contact with the families.

ISSUES AND RESOLUTIONS

Planning time

Issue: As is often the case, once funding was obtained, there was a sense of urgency to get the study underway. After selecting the sites and identifying the site directors and education directors, we had only three months to organize the study before the screening and enrollment of infants was to begin. One full year would have been more realistic.

Lacking time, we missed the opportunity to test in advance the data collection forms used in the first few assessment periods. (There were eight assessment points over the three-year trial—four in the first year, and two each in the second and third years. At each assessment period, we gathered anywhere from four to 14 forms of data from the study mother and child.) Because of problems experienced by the sites during actual data collection, we had to revise some of the early forms for the next assessment period. Hence our aim to keep the data comparable across all assessment periods was not always attainable in the early months of the study.

Resolution: We learned the merit of pilot testing in connection with the 12-month assessment. We discovered that because of language barriers or educational levels, many mothers did not understand the wording of an interview questionnaire we had planned to use. When this became apparent, we were able to obtain permission from the author of the scale to simplify difficult wording. Questions on another instrument were found offensive by study mothers. A third scale dealt with very emotional and personal issues and upset many of the respondents to the point of tears. Although we could not always alter the wording or eliminate an instrument from the battery, at the very least the pilot testing gave the staff a chance to discuss their experiences with one another, and prepare themselves to better deal with these difficult situations.

Pilot testing also allowed us to evaluate the length of time required to complete the battery of assessments, and to judge whether the time required exceeded the child's or mother's endurance. For example, the 36-month assessment, the last assessment period of the study, contained the final outcome measures. Looking upon this assessment as a "last chance" to collect data from this cohort, many investigators were tempted to request the addition of "just one more test" to the battery. Among other things, the pretest results showed the resulting length of the assessment to be intolerable! We found three hours was the maximum time during

Editors' note:

This issue of *Zero to Three* is about the growth of programs that serve infants, toddlers and their families. More specifically, it is about the management of growth.

The articles in this issue are based on experiences in the Hawaiian Islands and the British Isles; in university research centers and neighborhood child care centers; in programs that started on a shoestring and programs with multi-year multi-million dollar funding. Although their experiences with program growth, replication, and change are varied, the contributors to this issue address a number of common themes:

- **the struggle to achieve both flexibility and uniformly high standards of service;**
- **adaptation of staff to program growth and change;**
- **the role of program evaluation in guiding growth and replication; and**
- **the role of private foundations in supporting innovation and replication intellectually and financially.**

This issue of *Zero to Three* appears at a time when some programs affecting infants, toddlers and their families are already undergoing expansion, and when policymakers in both the public and private sector are calling for increased investment in the earliest years of life. We are grateful to our contributors for sharing their experiences of growth in such rich detail, with such candor and with such common sense. We hope that all of our readers who wish to see their programs grow will have the opportunity to do so, and that they will find their way made a bit easier by the hard-won wisdom collected here.

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which a child could perform optimally and the mother's interest could be maintained. As a result, we eliminated one instrument from the assessment, re-ordered the administration of the instruments, encouraged breaks with snacks, and increased the monetary incentive to the families.

Who "owned" the study?

Issue: The question emerged repeatedly: Who had the power to make final decisions—the funding agencies, the National Study Office, the Program Development Office, the Research Steering Committee, or the eight participating sites? The issue was felt most acutely by the sites, as they were required to implement a standardized intervention without participating in the initial research design. Some sites complained that the different management styles of the two national offices, each controlling one main branch (clinical or educational) of the study and each a continent away from the other, led to conflicting interpretations of how rigorously the study should be controlled.

Resolution: In most cases, final decisions were made not by any one group, but through consensus, achieved by dialogue and debate in memos, conference calls, and meetings. Particularly in the early stages of the study, these discussions served to establish and maintain a spirited, quality-conscious investigation. Looking back, however, we realize that the site directors and education directors should have been hired early enough to participate in the planning phase of the study. We could only try to compensate by including them in ongoing decisionmaking during the study. Although some benefits might have been achieved from housing the National Study Office and Program Development Office together, it was decided from the beginning that it would be important to keep the offices separate in order to maintain integrity of the data.

ROLES AND ISSUES FOR SITE STAFF

Site directors

Issue: The responsibilities involved in supervising a large, multidisciplinary staff created unanticipated stress among the site directors. Their time commitment exceeded expectation and salary support. Site directors who were physicians had had little or no training or experience in dealing with a staff of educators nor, in most cases, with a multi-site project. Furthermore, the limited access to study data for four years and the lack of time for scholarly pursuits made it difficult to produce the publications needed for career advancement.

Resolution: Weekly all-staff meetings were mandated at each site. An electronic mail system was set up to facilitate communication and support from the NSO and among sites. Accessible by telephone at all times, the NSO also arranged conference calls and three to four national meetings annually. The NSO and PDO both visited the sites.

The NSO encouraged and facilitated the site directors' conduct of their own ancillary studies by providing access to data in areas unrelated to study outcomes. The NSO statistical consultant freely and willingly provided support to these efforts. Two site directors were added to the Research Steering Committee to provide input from the perspective of the sites.

The funding agency increased the site directors' salaries to reflect their increased time commitment.

Education directors

Issue: The education directors felt that their role in implementing the education component of the program was as demanding as the site directors' role, but they did not feel co-equal with site directors. They felt pressured by the multiple responsibilities involved in running the child development centers—recruiting and supervising a large staff of teachers, home visitors and transportation crew; assuring the implementation of a standard curriculum; and delivering a vast number of accurate and complex data forms to the Program Development Office on a timely basis.

Resolution: The NSO gave the education directors full control of the budget for their areas of responsibility, but this never made up for the fact that they were not given co-director status with the site directors. To relieve some of the pressure, the education directors were permitted to hire assistant directors to supervise data collection and were given increased secretarial support. They were also provided with separate computers for relaying data and for electronic mail. The education directors were included in all national meetings with the site directors and were given enormous support from the PDO through telephone access and site visits.

Nurses and social workers

Issue: Providing service while following strict protocol procedures for collecting data frequently caused conflict and tension among the nurses and social workers. They were trained and monitored throughout the study so that they administered questionnaires uniformly. This procedure was important to prevent bias between the Intervention and Follow-Up groups and across the eight sites. Many of these face-to-face interviews with the study mothers dealt with emotional issues, such as depression. But because of the need for uniformity of data collection, the nurses and social workers could not pursue these sensitive issues and adequately show their concern; nor could they question responses, even when they believed them to be incorrect. Lacking supervisors of their own profession, and sometimes without a social worker at the site, some nurses felt burdened and ill-equipped to handle the emotional as well as the clinical responsibilities of the work.

The nurses and social workers often experienced turf conflicts with the education staff over the families. The nurses made themselves available as medical consultants to the education staff, but some nurses complained that when they gave advice, the teachers sometimes chose not to follow it. Even after three years, the two staffs could not always agree on the appropriate resolution of a child's clinical and developmental problems.

Resolution: The NSO provided support through semiannual training sessions, constant telephone availability, and site visits. At some sites, the site directors were able to provide helpful and timely support. In some instances, the nurses and social workers sought support from professional colleagues at their institutions. Ideally, every site should have had a social worker to assist in the support of multi-problemed families. Clearer guidelines from the NSO regarding the nurse's role in the child development center might also have been helpful.

Home visitors

Issue: The home visitors experienced head-on confrontation with poverty and family chaos in the multi-problemed families with which they worked, and had to face their inability at times to respond to the families' dire needs. They had to enter and work in crime and drug-ridden neighborhoods and homes.

The home visitors experienced turf conflicts with other staff over the families—they were accused of trying to play the role of social worker, nurse, and "best friend" instead of focusing on their assigned role as home educators. They often said they felt "burdened" by the information revealed by families, and constrained by the "promise of confidentiality." Such conflicts at times led to feelings of isolation and loneliness.

In the first year of the program, the home visitors felt handicapped by the lack of a medical background to help them respond to the problems raised by the mothers concerning the care of low birthweight infants.

Having to complete what seemed an endless number of data forms in a timely fashion further contributed to the home visitors' stress.

Resolution: This group, especially, needed a supportive counselor. The education director and, at some sites, counselors in their institution, provided support. The PDO was constantly available by telephone and made frequent site visits. Escorts were hired to accompany the home visitors to dangerous neighborhoods; at one site, home visitors only went out in pairs. To express appreciation and gratitude for their work, the Program Officer of the funding agency wrote a personal letter to each home visitor.

Teachers

Issue: The teachers experienced long days in the first year of the child development centers with one-year-olds, and in the next year with two-year-olds. Trying to meet the demands of the research protocol and the needs of the children was an unfamiliar challenge for most teachers. Some complained that the curriculum was "too prescribed," with little room for creativity and personal challenge.

Most sites had at least one child with severe handicaps, but no additional staff was provided to supply the intense extra attention required. Despite this additional burden, the teachers felt it was important to serve these children.

Teachers also experienced conflict with the clinical staff regarding appropriate remediation for developmental and clinical problems. They felt frustrated because the research design barred their access to the results of the children's developmental assessments. And since most children were transported to the CDC in vans by program staff, the teachers felt the lack of daily contact with the families. They had to rely instead on communication through the home visitors and transportation staff.

Resolution: Much of the frustration experienced by the teachers was balanced by the opportunity to work in a high quality program, in an environment with beautiful and ample equipment, very high teacher/child ratios, and small classes. Although teachers were required to follow the curriculum, they were given the flexibility to accommodate differences among children by adapting the curriculum to the level of each child. This allowance made following a set curriculum more palatable.

The PDO provided ample support through training sessions, telephone access, electronic mail, and site visits.

Study coordinators

Issue: The study coordinators' role and job description were inadequately defined from the beginning. As a result, other staff tended to give them any task they did not want or could not handle. The study coordinators had no professional peers on the IHDP staff or in the institution, and often no direct on-site supervisor. Although they had the major responsibility for gathering and forwarding timely, accurate data to the NSO, they did not have authority or remuneration commensurate with their responsibilities.

The study coordinators were responsible for getting families in for their assessments with in a prescribed "window" of time. This was a particularly difficult task, since many of the families had no telephone, moved frequently, or failed to keep scheduled appointments.

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Resolution: The NSO provided supervision and support through written and telephone communication, site visits, and national training sessions. The study coordinators were encouraged to view their roles as evolving and changing to meet the demands of the study. Half to full-time secretarial support was added at each site to relieve the clerical burden.

The NSO made a belated but sincere effort to define the role of the study coordinator and to urge other site staff to respect the defined limits.

Transportation staff

Issue: In the course of delivering the children to and from their homes and the CDCs, the van drivers had to cover diverse routes and, at some sites, deal with severe weather and/or traffic conditions. Frequently they found a child not ready for pick-up, or a parent not present for the drop-off at home.

Resolution: Drivers often became attached to families. They developed tolerance and provided assistance. Several drivers described going into the home, awakening and dressing a child, and putting him on the bus.

A "rider" was assigned to accompany the driver on every route. In addition, two-way radio sets were installed in all vans so that drivers could inform the site of delays, "no-shows," bus breakdowns and route changes. A staff person at each site assumed the role of transportation coordinator. Most sites credited the drivers with increasing child attendance in the CDCs and improving communications between families and staff.

GENERAL ISSUES

Maintaining the integrity of the data

Issue: To determine if the goals of the study had been met, it was essential to produce a high quality data set.

Resolution: Data collection forms were designed with the goal of ensuring data that would be comparable across sites and across the eight assessment points. Data collection procedures were highly structured and standardized. The staff received extensive training and were provided with a detailed manual for each assessment. With the collection of certain data, videotaping, audiotaping and reliability checks were used to monitor and evaluate the staff's compliance with the protocol. The major outcome measures were administered by staff who were "blinded" to the treatment status of the children. All data forms were checked thoroughly for errors and missing data, and were then incorporated into a comprehensive data management system.

Maintaining the staff

Issue: "Burn-out" affected all staff. The rigor of adhering strictly to the research protocol certainly had its own demands—an enormous amount of detailed paperwork and the requirement to maintain all families in the study, seemingly at whatever cost. The tension and frustration of working with multi-problemed families were a continual source of stress.

These problems were compounded at times by lack of cooperation and collaboration among team members of different disciplines. Most sites stated that poor communication between the medical and educational teams was a major problem, despite continuous efforts to improve relations. Fundamental differences in philosophy and lack of trust seemed to prevent the two groups from seeing an issue from any perspective but their own. There were disagreements about when to report child abuse; whether to admit a child with suspected AIDS into the child development center; and when special intervention, such as speech therapy, was needed. Since the education staff were based at the child development center of each site and the medical staff worked in the hospital clinic, a physical separation occurred that seemed to increase emotional distance between the two groups, promoting further estrangement.

An additional problem involved the need to keep staff for the duration of the study while supporting their search for new employment after the study closed.

Resolution: The NSO and PDO had to be available and willing to provide support at any and all times. National meetings were invaluable. Weekly staff meetings were very helpful at some sites. Small tokens from the NSO, such as tee shirts and other inexpensive but meaningful presents, also helped.

As interdisciplinary tensions developed and escalated, some sites fared better than others. We found that a combination of attributes of the site director and the education director determined whether the situation would work, or not. One site, where tensions were minimal, attributed its success to the explicit agreement among all concerned to concentrate on their common goal—helping the families. We also credited this site director, who religiously complied with the directive to meet with the education staff at the child development center every week.

A retrospective look at the study brought suggestions from many staff members:

- orient and train the medical and educational teams together;
- house the teams together;
- meet regularly and work with consultants or mediators when problems arise;
- hire individuals who have overlapping backgrounds; and
- continually emphasize the research goals and remind staff of their commitment to the project.

It would have been ideal if all staff could have had access to an independent counselor. And many sites found that when the full staff was brought together, not only on the job but socially as well, relations improved.

In the last year of the study, a committee from the sites, the PDO and the NSO sought meaningful solutions to the issue of future employment. Consultants were brought to the sites and to national meetings to advise on career choices and placement. Assistance in writing resumes was offered, and liberal time off was allowed for job interviews.

Maintaining the study cohort

Issue: For the integrity of the study, it was important that all the families participate in the scheduled assessments, and that the families randomized to the Intervention Group participate as fully as possible in the intervention services.

Resolution: The protocol called for the staff to follow a number of procedures to prevent the loss of study subjects. Among these were mailing "reminders" one week prior to the next appointment, placing a minimum of two telephone calls to each family between appointments, and making a home visit if no other contact had been possible.

In addition, a number of incentives proved effective. Polaroid pictures were taken of each child at each of the eight clinic visits and presented to the families in a picture album. Diplomas were issued at 12, 24 and 36 months. Holiday and birthday cards (sometimes the only ones the families had ever received) were sent regularly throughout the study. We found that cash payments to families were one of the most important incentives for participating in scheduled assessments. For intervention families, transportation to the CDC seemed essential to maintaining the regular attendance of children.

For the final 36 month assessment, we hired, trained and sent special assessors to 21 states throughout the country to obtain data on 37 children who had moved too far away to return to their site.

When all is said and done, it was the relationships formed with staff at each site that kept families in the program. "Bonding" began on initial contact with the family in the hospital nursery. Throughout the program, all staff were available and willing to provide support.

The rewards

At the end of the Infant Health and Development Program, the National Study Office held debriefing sessions with staff at each site. There was a clear consensus that no matter how stressful the experience had been at times, it had been well worth the effort. Over and over again we heard staff members comment on their own growth as a response to the variety of responsibilities and challenges, the rigorous attention to detail and quality, and the experience of working with other disciplines. Indeed, many staff were inspired to further their professional education. Most important were the joy and pride in knowing that the study had been performed well and that the results would have important policy implications.

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Empowering Parents—the Evolution, Evaluation and Expansion of a Program

by
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The well-being of the infant child and its parents are issues of immense importance, aware as we are aware of how strongly the child's health and development in the first five years can affect its entire future. In the United Kingdom the battle is being waged between what one might call the narrow professional model and the broad environmental model. The narrow model sees the well-being of the child as the particular concern of doctors, health visitors (public health nurses), social workers, psychologists and others, with parents on the periphery of concern. The broad model sees the child's well-being as depending primarily on the wider environments of parents, home and community, so that real and lasting improvements in well-being can only come about, as Urie Bronfenbrenner has pointed out, through changes in the careers of those children.

If successful, our program variants may indicate that the underlying model of empowerment has a fundamental strength which can survive transposition to other environments.

This paper sketches some of the rationale, the problems and successes of the Child Development Program, a nation-wide operation now covering nearly 30 health authorities in four countries on this side of the Atlantic—England, Northern Ireland, Wales and the Irish Republic.

After an initial period of experimentation and establishing its effectiveness, the program has spawned variants which are more suited to particular communities or situations. This is an exciting development, because if successful it may indicate that the underlying model of empowerment and capacitation has a fundamental strength which can survive transposition to other environments.

The biggest challenge to the program has not involved the field work itself. When people are empowered and given information to enable them to use their new-found power or control over their lives, they do not easily reject the new insights or revert to a state of dependency and hopelessness or failure. The biggest problems and setbacks have arisen through trying to persuade professionals that this kind of motivation can only enhance their role, provided they recognize the need to move into the background and surrender the expert status on which so many depend for job satisfaction.

The many hundreds of professional health visitors who have made this transition—some indeed needed little or no training because they already operated within an empowering framework—are the best witness to the fact that within the body of professionals there are a significant proportion who are open to change and reform. But it remains a slow process. Bureaucratic structures and the remnants of a strong class system in the United Kingdom adapt slowly and cautiously to innovative ideas. Government pressure for cost-cutting in all the major services adds to the understandable caution about moving away from existing systems.

Evaluation has played a central part in the development of this new program. It has been the only serious effort to evaluate the effectiveness of health visiting, and yet its several massive evaluations are still matters of contention among some professionals, as are the ethos and philosophy of the program. By contrast, evaluations which support existing systems and reflect current paradigms are often accepted without reservation because they reinforce rather than question the status quo. This remains a serious problem for the program, echoing the early US research study which "proved" that Head Start was unsuccessful, a claim subsequently disproved.

The intertwining of innovation, research and professional politics is inevitably a minefield. The fact that the development of the program has been strongly supported throughout its formative years by the funding and professional advice of the international Bernard van Leer Foundation, has been the most significant factor in enabling the work to continue despite numerous obstacles.

Evolution

Throughout the 1970s a multitude of child development programs were featured in journal articles and other publications, many of them innovative US initiatives. Most of these programs adhered to the narrow model described above, with professionals, paraprofessionals and even trained lay people "doing things" to the infants and children, with the parents expected to sit on the sidelines and admire the expert work of others. Such programs had some success, but they were also disempowering in their long-term effects. Reports described how this or that group of psychologists, pediatricians, nurses or professionally guided lay people had achieved wonders in changing the environment for the child (or indeed the fetus), and thereby helped its development.

A good example of the narrow model was seen in the UK at a national conference in the early 1980s, devoted to the theme of the disadvantaged child. The psychologists and others present succeeded in focusing a whole day of impressive talks and discussions on every aspect of child development other than the role of the parent. The only mention of parents occurred in a talk on maternal depression.

Some parents feel awkward about touching

But there's nothing wrong with touching babies and children in a loving way

Young children understand loving best through touch. Touching and saying loving things helps children feel secure

Refusing to touch, makes children feel rejected

EVEN NAUGHTY CHILDREN NEED A LOT OF LOVING

Now don't smack your little baby brother again!

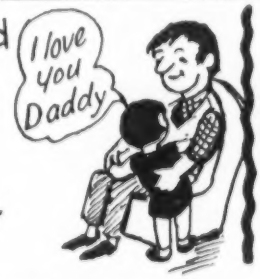
When praising children, a kiss and a cuddle mean much more than yet another sweet

IN INDIA babies are massaged with scented oils, especially when they are ill

IN CHINA, massage is used to relax **upset children** by touching acupuncture points

IN COLOMBIA premature babies need a lot of touching and holding, even when they are asleep

Touching and Holding help physical and emotional development



All babies need a lot of touching and holding, even when they are asleep

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Artist:

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The few programs, American and British, which focused on parents within the broad environmental model referred to above, were like beacons of light in a dark sea.

Parents now seen as key agents

A tremendous change has taken place over the past ten years. Ever more programs are coming to identify the parents or other principal caretakers as the key agents for developing the child. Experimental programs are focusing deliberately on what the parents can be helped to achieve.

When we started the Child Development Program at the beginning of the 1980s—a dream of supporting and empowering the young parent had been part of the mental framework of myself and others for decades—this concept was still seen as radical in the UK context. For many reasons it seemed appropriate to ground the program on the health visiting profession, health visitors being public health nurses who visit as of right every parent with a newborn child, continuing the visiting intermittently or when needed throughout the pre-school years. Having access to every home, health visitors are not viewed as being concerned mainly with resolving the social or other problems of parents, but rather as concerned with the health and early development of the young children.

The broad social basis for our program is essential. Low income families understandably resent programs targeted entirely at them and seen as designed to compensate for their "deficits."

We could find no source of funding in the United Kingdom—the best UK research offer we had, in response to our proposal for a program focused on 300 families—was that we should concentrate the proposed program on ten families for two years, something which would have been grossly intrusive in the lives of the families concerned.

The Bernard van Leer Foundation, an international organization committed to the funding of collaborative child and parent support programs in disadvantaged communities throughout the world, gave a very different response. The then Executive Director, Dr. Willem Welling, a former Director-General of Unesco, challenged our goal of working with only 300 families. "Why so few?", he asked. It was the green light we needed.

Experimental phase of program

We started with 1,000 families, spread over six health authorities; four in England, one in Wales and one in the Republic of Ireland (Dublin). The massive evaluation of that first, experimental program is described later in this article. It took nine months to recruit those authorities (out of a total of some 200 in the UK). The inclusion of Dublin was to prove a godsend because it was there that we later switched to a community-based rather than professional-based visiting program.

The nature of the program needs to be described briefly.

Although the program is focused primarily on empowering those parents who have the least power and influence over their lives and the lives of their children, it was seen as important that it should not become labelled as a program only for low income or disadvantaged parents. In the first phase program there were approximately 15% advantaged parents, and in the current large scale field program there are some authorities with up to one-third of parents who could be described as advantaged. This broad social basis is essential, as there is much understandable resentment among low income families over programs targeted entirely at them and seen by them as compensating for their supposed "deficits."

In the experimental phase there were some 650 experimental families and 400 control families, the larger number of experimental families enabling some important additional analyses to be undertaken on various program effects.

All 650 families were given a two-year intervention program in which they were visited by their normal health visitor each month for about an hour. The health visitors were given a short period of preparation for this work and throughout the two years they had regular monthly in-service training sessions.

Structure of home visits

During the home visits—all made by appointment—the visitor discusses how the parents have coped with the tasks agreed at the previous visit, what new developments the parents have observed in the child, what the child has eaten the previous day, and equally important, what the mother has eaten, how the child's health has been in that period (as seen both by the health service and by the parents themselves), and finally there is a discussion on what the parents (often only a single parent) want to achieve with the child in the coming month.

Two other features of the program also make it stand out from anything else. The visitors use a progress form to structure the visit and keep both themselves and the parents "on track," so that it is seen as a working visit, though a very friendly and informal one. The second feature is the discussion and handing out of cartoon sheets illustrating, in a mildly humorous way, various problems of child-rearing and ways in which these might be overcome. The cartoons cover every area of functioning, including nutrition, health, language, early education, social and cognitive development and general issues (such as the mother's self-esteem). The training of the visitors emphasizes that these cartoons are not to be used didactically, but rather presented as something for information and debate, with parents being encouraged to question the ideas.

The whole emphasis of CDP program visiting is to encourage parents to become aware of their own potential for self-help, their inherent parenting skills which they need to identify and foster, and most of all their power to control and influence their own

environment and the rearing of their children, even in situations of disadvantage. The home visitors' role is to help to empower the parents and to give them the information they need to build up their own skills or "capacity."

Early findings from the experimental program, in particular the experience of nursing managers and others who went out to visit parents who had received the program for up to two years, was that impressive changes had occurred. Some families who for generations had been visited by welfare workers and health visitors because of their serious and endless problems, had in a short space of time become functioning families with an optimistic life perspective very different from the previous apathy and sense of failure.

It was to take another four years before the first major evaluation was completed on some 4 million items of research information. But the evidence of field workers and former critics, and of a great many parents themselves, was that it was a program worth pursuing.

Field workers liked program, but could not continue with it!

The only problem for the Unit directing the program was that although all 46 intervention health visitors agreed that it was a great program, with a lot of potential, they personally felt they could not continue with it. This was a devastating conclusion. But the reasons were understandable.

Because of the growing social disintegration in UK society, health visitors working in marginal areas have found that a major part of their visiting time is spent on what they describe as crisis visits to older families. In other words, instead of having the time to visit new families and support their early efforts at adequate feeding and stimulation of the infants, health visitors find most of their time taken up with trying (usually in vain) to help parents resolve their latest crisis, whether it concerns welfare, health or personal issues.

During the years of the experimental program these visitors had frequently found themselves faced with a choice between responding to the latest family crisis within their ordinary non-program caseloads, or undertaking the planned program visit for which the parents were waiting at home, by appointment. The visitors said they could no longer accept such a conflict of duties.

New administrative structure

After much agonized discussion with all the authorities concerned it was decided to alter the structure of the program. In future, in authorities which agreed to participate in the ongoing field program (no longer an experimental pilot), teams of health visitors would be identified in specific areas of the authority, and within these teams one in every four visitors would be selected to visit all first-time parents (thus the name First Parent Visitor); meanwhile their colleagues (Family Visitors) would take over all the families with two or more children and visit them when necessary, in the ordinary way.

This meant that all new parents within targeted areas would receive the program for eight months or longer, depending on their level of need; parents with two or more children would receive program visiting only if they were experiencing serious difficulty with their child-rearing.

The new development got under way in 1984. Again it was extremely difficult to persuade health authorities to participate. There were many reasons for this—the inevitable problems of change, but now also the increasing pressure on health service funds, with competition for resources from the much larger hospital or "acute" sectors. Three of the original six health authorities pulled out of the second phase; in two cases it was the top managers who decided they did not want any kind of health visitor "specialization," despite the willingness of some of their line managers and staff to continue; in the third case the manager was very keen to adopt the new program, but there was considerable resistance from a determined and highly politicized group of field staff who saw this program as threatening their professional status.

It took years for a courageous minority of public health nurses and administrators to persuade their colleagues that home visiting by "community mothers" was not a threat to the future of community nursing in Dublin.

Despite the difficulties of finding authorities to undertake the modified program, by early 1991 the Child Development Program had spread to nearly 30 health authorities, with about 18,000 new families receiving the pogram each year from a total of over 200 specially trained health visitors.

Dublin: the community mothers variation

Meanwhile an exciting development of the program was taking place in Dublin. There the public health nurses, operating in a different administrative environment from that in UK health authorities, felt unable to accept even the modified version of the professional program, since their normal work had a large component of domiciliary nursing of the sick.

We were very keen to maintain the program in Dublin and it seemed that the only remaining resource should be tapped, namely the community itself. I proposed that experienced mothers should be recruited from the areas where the program had been operational—including some of the most disadvantaged housing estates in Europe—and that these home visitors or "community mothers" could be trained to do program visits to new parents. The proposal was greeted with dismay, particularly by the profession itself, and it took years and the work of a courageous minority of committed public health nurses and administrators, to persuade their colleagues that this program was not a threat to the future of community nursing in Dublin.

Today there are 150 community mothers operating in that city, visiting upwards of 1,000 new families each year. They are paid a small amount for their work,

which some of them see as a stepping stone to acquiring the confidence to go out later into fully paid employment. Others are happy to continue with the visiting work. The training of the community mothers is, like that of the health visitors in the CDP, ongoing—with a seminar each month, and individual support from a specially trained public health nurse for each community mother. These lay workers have had a tremendous welcome, after a brief period of initial doubts from other mothers on the estates; their involvement in such critical work is seen as the start of community empowerment.

At first the grandmothers were particularly resistant to the idea, often claiming that "if anyone is going to tell my daughter what to do (with her baby) it is going to be me"; but they were won over by the non-didactic and supportive nature of the community mothers, who were selected on the grounds of their competence as parents and their empathetic personalities. Academic qualifications were not considered in the selection process, provided the mothers were sufficiently literate to handle the forms and cartoons.

The best tribute of all came from the Irish Nurses Organisation, which now regularly features community mothers as speakers at its conferences. The success of the Community Mothers Program in Dublin has inspired the beginnings of a community mothers program in the UK, as described later in this article.

Evaluation

The evaluation of any action research program is fraught with problems. The fact that it is not a laboratory type study, with matched samples and other stringent controls, means that one has difficulty communicating with those professionals for whom a double blind controlled trial is an article of research faith.

The nature of action research also means adding complexity to what would otherwise be a straightforward test of a simple hypothesis. Action research is messy, there is a continual attrition of real life people from the sample; even worse, research staff themselves can move on and the careful training that went into one of the original researchers has to be somehow repeated on a new member of staff in mid-stream. The statistical analysis of action research programs is far more involved than that of more basic research such as pharmaceutical or other medical trials; multiple regression and similar multivariate analyses are essential if any meaning is to be drawn out of the mass of data gathered in the field programs.

The nature of the original experimental Child Development Program—the two-year "intervention" by randomly selected health visitors, working with a randomly selected sub-set of their normal caseloads of families, and comparing the outcomes (clusters of parent environment and child development variables) with outcomes from control families who had been visited by control health visitors—required extensive evaluation interviews with each of more than 1,000 families at the beginning, middle and end of the program. Needless to say, all the normal research protocols were observed, such as random allocation of intervention and control health visitors, random selection from among the visitors' families, and other experimental controls.

We looked for evaluators who were intellectually bright people with origins in the community and who understood not only the ethos and cultural habits of families but also the nuances of the regional dialect.

Conceptual problems over choice and work of interviewers

At each point in the development of this program, especially the evaluation design and analysis, challenging conceptual issues arose. The evaluation model was based on four separate "regions," and there were separate interviewing panels for the appointment of interviewers in each region. Each time we had the difficult choice of whether to select interviewers with a handful of university qualifications, from a stratum of society alien to most of those whom they were to interview, or to select intellectually bright but less qualified people who originated within their own communities and who understood not ony the ethos and cultural habits, but more crucially who understood the nuances of the regional dialect—somehow we always ended choosing the latter.

Some commentators have had difficulty in understanding how these interviews operated. Why, they asked, did we not rotate the interviewers? One answer will be apparent from the previous paragraph. Even when we occasionally brought two interviewers together to do joint interviews, as a way of checking implementation of the questions and the answers, the interviewer who did not belong to a region's particular sub-culture and dialect found it difficult to understand the nuances of some of the answers, as she did not share in the common sub-culture.

Another answer lay in the fact that most of the interviewers were women with families of their own, living in areas hundreds of miles distant from the areas covered by other interviewers..

We have also been asked: were the interviewers blind as to who was intervention and who was control? We point out that the interviewers certainly were blind on their first visits. Visiting up to 200 or more families each, they were unaware of whether an individual family was due to be intervention or control. The interviewers were instructed not to discuss nor attempt to find out details of the program during the three years of interviewing.

But once the program was under way the families could not be "forbidden" to speak openly to the interviewers about what was happening to them. Many families did indeed tell the interviewers on the second or third annual visits, often enthusiatically, that they were getting a special program with cartoons and ideas about developing their children.

The interviewers were cautioned on various occasions that their sole task was to report as objectively as possible what they found; they were not employed to help carry out or support the program, but merely to "report" on it in the form of their very detailed two-hour interviews with each family every year.

Difference between action and laboratory research

It was evident that the evaluation of the CDP had to be very different from a laboratory model. Even had a new set of interviewers been trained for each annual survey, the intervention parents would still have spoken to the new interviewers about their experiences, though there was nothing in the interviews which referred to the program. On the contrary, the probing nature of the questions about the child's development and the interviewers' neutral inquiries about what the parents might be doing to stimulate the child, had the embarrassing effect of conscientizing some of the control families. In subsequent years several control families confessed to the interviewers that the questions which they had been posed the previous year had made them aware of what they were not doing for their children, and led to a change in their child-rearing practices.

The nature of the interview formats used for this program was also unique in that only a few conventional test instruments were used, and even these were combined with a variety of other more relevant measures of child development or family stimulation patterns. Thus, for example, although the picture vocabulary test was used as one of the measures of language comprehension, more than 20 other items and measures were also used to build up a more precise and more valid assessment of the child's language competence, with advanced statistical techniques being used to weight the items employed in deriving this measure. Other well known instruments were modified by having analog scales fitted to the items to give a broader range of answers than the rather simple yes/no or all the time/50% of the time/never responses. Among these instruments was the Present State Examination, which was used in analog scale form together with a range of other measures to evaluate maternal self-esteem.

For us the whole approach to evaluation was designed to increase the validity of the assessment, even if, as is inevitable, there was a slight reduction in reliability. All too often research designs follow the opposite path, aiming at such high reliability that the work has little validity and little relevance to real life situations. In this regard the writings of Leo Cronbach have served as a guiding light in the present and earlier research by this author.

The interviews themselves took two or more hours, with different interview protocols reflecting different aspects of inquiry (child's development, nutritional intake and status, parent environment, maternal self-esteem, and child behavior). As noted earlier, in total some four million items of information were gathered and coded.

Views of field staff and managers

Nearly all the nursing managers in the program areas, and virtually all the intervention visitors, concluded that the program was making powerful inroads and helping to change child-rearing practices. They were very keen for the program to continue, even though as pointed out earlier, the visitors themselves were not prepared to combine crisis visiting with the prevention and support type visiting demanded by the program. Intervention parents were also enthusiastic and many said that they wished they had had this program in time to help them with their first child; others wished that one of their friends could have had the program rather than the conventional forms of health visiting.

It was surprising to find that in none of the health authorities were there any visitors saying that despite the work they had put in, the program had had no effect. The argument was always one of resource limitation and the conflict of duties.

Given the momentum of the program, and the favorable reports not only from participants (which can often be expected from people who have put effort into a new program), but from outside observers and from hard-pressed managers who by nature were not keen on having their staff diverted to new initiatives, it was decided to go ahead with a modified program and endeavor to extend that to other authorities.

In retrospect we are glad that we did not pause for years while the data coding and analyses were undertaken—procedures which demanded great care and much research time. The highly positive results, when they appeared, confirmed our initial findings and supported the impressions of managers and visitors that the program was indeed effective.

We are glad that we did not pause for years while the data coding and analyses were undertaken.

Our main results were published in a comprehensive program research report in 1988. Using multiple regression and other techniques, we were able to show highly significant effects of the program, often below a probability of .001, on nearly every aspect of the parenting environment, within three of the four regions.

We had set out to bring about these changes in the parenting environment, arguing, as do Bronfenbrenner and many others, that changes in the parenting environment are far more persistent and meaningful than are attempts by outsiders to alter children's development directly. We were also able to show significant effects on the young children's development in these regions.

At some stage we hope to undertake a follow-up study of program and control children, who are now well into their school years, to assess whether the changes in parenting environment have had long-term effects on the children.

The fact that the program effects were only modest and sometimes non-existent in the fourth region was, understandably, troubling for our team. The reason became clear when we examined the social profile of the control sample in that one region. Unlike all the other areas, selected because of their relative disadvantage, this one control sample was noticeably advantaged—so much so that during the interview period the interviewer in the region complained that she was seeing dozens of very affluent families in one area; unknown to her, this had been selected by service managers as the main control area for that region.

Monitoring of achievements in current field program

The monitoring of the current field program covers tens of thousands of families and, although it does not have the research depth of the original experimentation evaluation, the monitoring is done independently by each health authority, using a field instrument which we have devised. Information for the monitor is gathered by the health visiting staff of each authority, is input on to computer by its own coding clerks, and analyzed separately by the health authority staff and sometimes by ourselves as well, to gain fresh insights into the progress of the program.

The field monitor offers a considerable amount of information of much epidemiological relevance to the health authorities. Unlike the more broadly based evaluation model of the experimental phase, where several thousand different items of research information were gathered, the current monitoring—based on an instrument termed the Early Health and Development Monitor—yields a total of only 180 items of focused information on each child's health, nutrition, and early development over the first four years of life. Typical examples of monitor indicators are key facts such as days spent in hospital, a one-day dietary recall with the visitor estimating the adequacy of seven key constituents of food (e.g. were there any wholefoods such as brown rice or brown bread, how adequate was the milk intake, etc.), and simple assessments of language, cognitive and social development, together with estimates of maternal self-esteem using four very simple psychiatrically-oriented questions scored on analog scales, and a similar analog scale question as to how much the mother's partner is involved in the care of the child.

A strong feature of this instrument is that all the information is automatically analyzed within socio-educational categories. Tables on different indicators provide information pointing to the wide disparities between rates of infant hospitalization, diet, immunization, etc., across three (or five) levels of socio-educational advantage or disadvantage. This helps managers (and field staff) to recognize how much the social background and mothers' education influence such indicators. This is a unique development within a health service field program.

The idea of encouraging health authorities to undertake the monitoring of their own program achievements is not necessarily new. But putting into their hands a fairly sophisticated monitoring instrument is quite an advance on the normal approach of either bringing in psychologists and other researchers to do that evaluation, or getting field staff to use instruments so basic that they are open to misuse or to being misunderstood—particularly if the measures are not adequately controlled for socio-educational differences across the authority.

Expansion: the political challenge

The expansion of any program involves weighty considerations. Most important of all, is there sufficient evidence to justify expansion? For those sympathetic to the program philosophy, the expansion is overdue and should proceed with all speed. Such people have often had a close association with the new initiative and from their personal experience they believe that it is effective. For those hostile to the program philosophy, there may be residual doubts as to its effectiveness; they argue that the apparent achievements of the program may be simply due to the fact that the health visitors put more time into the program parents. Counter-arguments that other programs involving additional health visitor time have had only minimal results are dismissed on the grounds that the situation is not the same.

The debate over expansion is wearying. It involves the difficult topic of empowering parents, even the most disadvantaged, so that they can enjoy equal status with professionals. It also involves inter-professional issues.

It becomes a wearying debate, with strong political overtones relating to the parents vs. professionals issue, and to the difficult topic of empowering parents, even the most disadvantaged, so that they can enjoy equal status with the professionals. The debate also involves inter-professional issues. The program believes strongly that health visitors, as the key agents of prevention, health promotion and development at field level, should themselves be empowered so that they are no longer professionally subservient to other health professionals. This is understandably a contentious issue. The same topic is being debated internationally; how much autonomy should nurses enjoy in relation to doctors? Are nurses by definition subordinate, or do they have a role alongside and of equal importance to that of doctors? How much is this power relationship influenced by the fact that most nurses are female and most doctors are male? They certainly are in the UK and many other Western countries.

Problems of expansion and funding

Other questions about expansion are of critical importance for the Unit itself, which has developed this program in collaboration with a large number of health authorities and their staff.

In expanding the staff of any initiative there is always the danger of reaching a point where the staff become a bureaucracy in turn, merely replacing old bureaucracies and old dogmas. In our own case the Unit team has been kept small and closely knit, with as much of the training initiative as possible devolving to the health

authorities as soon as their staff have the needed experience to take over the main responsibility for further program training of their own visitors.

Funding is another permanent problem. In the UK, new initiatives based on state services need some form of State or local government backing if they are to continue. As noted earlier, funding from the Bernard van Leer Foundation was essential to launch this program and maintain it during the costly pioneering phase, and also in the subsequent development phase during which health authorities started paying an increasing share of the costs of training and program materials. A valuable recent development has been the decision of the Welsh Office—the Government office responsible for administration in Wales—to encourage health authorities in that country to become collaborating authorities within this program. Welsh language materials are in preparation for use in areas with large Welsh-speaking communities.

Many innovative programs in the UK have come to an untimely end because funding has dried up; the problem of how to fund innovation remains of central concern to researchers concerned with the development of new initiatives. The more that the initiative has an impact on current services the more problematical the funding becomes, especially because the nature of such programs raise large questions about the relationship between the families or individuals who constitute the "public," and the professionals around whom the services are built—whose vision of their role and power may be very different from that of the public whom they serve.

Growth of other initiatives

In recent years the expansion of this program has been accompanied by the initiation of new related programs alongside the Child Development Program.

Last year an Asian Parent Program was started alongside the CDP in one of the UK's major cities. Although this ethnic venture is still very small, it holds out much promise for the future of the Asian community in Britain. Currently there is serious concern about the fact that Asian families, because of language and cultural barriers, do not benefit from the health service as do white families. The new program set out to overcome that problem by identifying Asian health workers who are now spearheading a visiting scheme in which experienced Asian mothers are recruited and trained as community mothers, to do program visits to other Asian families within their own neighborhood or cultural group, using their own language or local dialect together with cartoons translated and sometimes modified to suit the different cultures.

As mentioned earlier, a UK-based Community Mothers Program has been started by the Unit in one health authority, and other authorities are considering starting as well; in most cases this venture will run alongside the Child Development Program. The health visitors will continue to do program visits to new families, as well as running baby clinics. The work of the community mothers will be centered on home visits to existing families which have run into problems in coping with child-rearing and development. It is believed that the skill and wisdom of more experienced mothers living within a community—even if it is a low income community with a high level of social stress—can be of great value to other mothers and fathers who have run into difficulty with their parenting. Experienced mothers from within a community have a "street credibility" which no professional could ever have, unless she or he lived within the area.

Other planned initiatives are also focused on the two central concepts which underlie all the programs, namely empowerment and capacitation. Empowerment to enable parents to get back the control which they have lost through life experiences or exploitation by others; and capacitation because helping people to feel in control of their lives and able to cope with the lives of their children, is of little value if it is not matched by learning the skills and developing the capacity to use that power effectively and sensitively.

Challenge to professional control

In the UK context these programs are unusual because by their existence they challenge present frameworks of professional control and leadership. In some countries, particularly developing countries, such programs would not be thought of as out of place, as there are relatively few professionals employed, having only limited power and faced with a vast amount of work requiring their professional expertise. In the UK and in many other developed countries, the professionals are in a dominant and influential position, able to dictate many aspects of people's lives, particularly if these are low income parents with young children. Here the absence of parental power or control is totally disabling within a situation of disadvantage, because it leaves people apathetic and unable to take their lives in hand; the effects on their children are even worse.

For some people the answer to the problems of inadequate parenting lies in a massive increase in professionals who can administer a form of benign control in order to train the parents, protect the children and, hopefully, bring about meaningful change in the families. For others, and that includes not only our Unit team and the many health professionals now collaborating in these programs, but also a great many people who question the current official approach to families, the answer to the problems of inadequate parenting lies in empowering those who are at the heart of these problems—the parents themselves—so that it is they who become the key agents of reform, with professionals as essential backroom staff, able to provide expertise when needed but accepting that their role is at most that of facilitator.

We still have a long way to go in achieving that goal. Fortunately there are thousands of people who are already committed to working in the same way, not only in this program but also in other initiatives which are in essence empowering of ordinary people.

Healthy Growth for Hawaii's "Healthy Start": Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect

by
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In July, 1985, a demonstration child abuse and neglect prevention project began in Leeward, Oahu, a multi-ethnic, mixed urban and rural, fairly depressed community, with more than its share of problems—substandard housing, underemployed adults, substance abuse, mental illness, and child abuse and neglect. Three years later, an evaluation of the program revealed that not a single case of abuse among the project's 241 high risk families had been reported since the demonstration began. There was also evidence of reduced family stress and improved functioning among the families served.

By July, 1990, Healthy Start/Family Support services were expanded to 11 sites through appropriations of almost $4 million by the state legislature and reached approximately 52 percent of at risk families of newborns throughout Hawaii.

The success of the 1985-1988 demonstration project was, of course, gratifying. But what may be even more remarkable is the institutionalization of the Healthy Start program within the Maternal and Child Health Branch of Hawaii's Department of Health, and the state legislature's willingness to support the expansion of a program without sacrificing quality. For as Lisbeth Schorr (1987) reminds us:

> The temptation to water down a proven model in order to distribute services more widely is ever present. Agonizingly familiar is the story of a successful program which is continued or replicated in a form so diluted that the original concept is destroyed. . . . Especially when funds are scarce, there are powerful pressures to dissect a successful program and select some one part to be continued in isolation, losing sight of the fact that it was the sum of the parts that accounted for the demonstrated success (p. 275-76).

In this article, we hope to describe the critical elements of the Healthy Start program and also to examine the processes of collaboration and advocacy that have made high quality expansion possible.

The Healthy Start model

The Healthy Start approach is designed to improve family coping skills and functioning, promote positive parenting skills and parent-child interaction, promote optimal child development, and, as a result, prevent child abuse and neglect. Nine complementary features make up the Healthy Start approach.

1. Systematic hospital-based screening to identify 90 percent of high risk families of newborns from a specific geographic area

Paraprofessional "early identification" workers review hospital admissions data for childbirths to determine which families live in the target area and are therefore eligible for services. Using a list of risk indicators developed by the Hawaii Family Stress Center (see figure 1), the early identification workers analyze the records of eligible mothers. If a screened record is positive, the mother is interviewed by a worker who has been intensively trained in basic interview techniques and in use of the Family Stress Checklist developed by the E. Henry Kempe Center and validated by Murphy and Orkow in 1985 (Kempe, 1976; Orkow, B., Murphy, S. and Nicola, R., 1985). Families determined to be at risk are encouraged to accept home visiting services; these are described to the families as home visiting, supportive services to assist with problems discussed during the interview and to share information about the baby's care and development. During the three-year demonstration period, 95 percent of families accepted the offer of services.

Figure 1.
Risk Indicators Used in Early Identification

1. Marital status—single, separated, divorced
2. Partner unemployed
3. Inadequate income (per patient) or no information regarding source of income
4. Unstable housing
5. No phone
6. Education under 12 years
7. Inadequate emergency contacts (e.g., no immediate family contacts)
8. History of substance abuse
9. Late (after 12 weeks) or no prenatal care
10. History of abortions
11. History of psychiatric care
12. Abortion unsuccessfully sought or attempted
13. Relinquishment for adoption sought or attempted
14. Marital or family problems
15. History of or current depression

Systematic identification of at risk families is key to the prevention of child abuse and neglect. The initial Healthy Start demonstration project set up the procedures for screening and risk assessment described above at four major medical centers that served the target population. A quality control review conducted in the third year of the project revealed that it was successfully reaching about 75% of the geographically eligible population as defined by hospital birth records, verified by the Department of Health. Procedures were

FEEDING ME

When I'm hungry, I'm really hungry ... please don't let me wait! I won't understand and I'll get upset and cry.

When you feed me, you'll want to be comfortable. I need this too. Sit in a relaxed position, with your arm supporting me. Please look directly at my face so I can see you ...

Gently brush my cheek and I will turn in that direction for the nipple.

Figure 2

instituted at Kapiolani Medical Center, the Regional Perinatal Center where 50 percent of all births in Hawaii occur, to correct factors, such as inaccurate reporting of addresses and lapses over long holiday weekends, that led to missed cases. This process has resulted in 100 percent coverage of eligible families at this medical center. Work continues with other hospitals to establish similar procedures. The systematic identification process holds great promise for targeting prevention programs to specific geographic areas, such as districts, counties, or states, in a systematic, comprehensive manner.

2. Community-based home visiting family support services, as part of the maternal and child health system

Once a family has accepted the offer of service, a paraprofessional family support worker contacts the mother in the hospital to establish rapport and schedule a home visit. Initial visits are usually devoted to building trust, assessing family needs, and providing help with immediate needs such as obtaining emergency food supplies, completing applications for public housing, or resolving crises in family relationships. Workers focus primarily on providing emotional support to parents and modeling effective skills in coping with everyday problems. Their "parent the parent" strategy allows initial dependence before encouraging independence. "Do for, do with, cheer on" sums up the workers' philosophy.

Workers also model parent-child interaction. They complete the Nursing Care Assessment (NCAST) HOME Feeding and Teaching Scales (Barnard, 1983) when the infant is four months old to identify problem areas, and again at twelve months to determine progress and modify intervention strategies. Workers use the Hawaii Family Stress Center's own parent-child interaction materials (see Figure 2) as well as Mary Alger's *Mother-Baby Playbook* (1976) and activities from Setsu Furuno's *Hawaii Early Learning Profile* manual (1984).

3. Individualizing the intensity of service based on the family's need and level of risk

A system of "client levels" and "weighted caseloads" is designed to ensure quality service for families and prevent burnout among staff. All families enter the program at "Level I" and receive weekly home visits. The decision to change a family's level is based on criteria such as frequency of family crisis, quality of parent-child interaction, and the family' ability to use other community resources. As families become more stable, responsive to children's needs, and autonomous, the frequency of home visits diminishes. A family's promotion to Level IV means quarterly visit status, and quarterly visits continue until the target child is five years old. Thus service intensity is constantly adjusted to the needs of the family, assuring that families who are doing well move along, and those needing more support are not promoted arbitrarily.

The system of client levels assists in caseload management. In the first year of a program, all families would be Level I; the caseload for each worker would be no more than 15 families. In the second year, some families would have progressed to Levels II and III; the

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average caseload would be 20 families. By the third year of a program, the average caseload would be about 25 families.

4. Linkage to a "medical home"

As its name suggests, the Healthy Start program emphasizes preventive health care as an important aspect of promoting positive child development. Each family is assisted in selecting a primary care provider, which might be a pediatrician, family physician, or public health nursing clinic. Project staff use a special computer system to track both due dates for well care visits, using the child's age and the schedule of visits recommended by the American Academy of Pediatrics, and for NCAST visits. Each worker receives a monthly printout of the children in her families who are due for visits, and follows up to make sure that the visit is scheduled and the family has transportation. Family support workers routinely conduct RPDQ's and make referrals for follow-up Denver Developmental Screening Tests as indicated. The program's office manager or the family support worker contacts the pediatricians' offices as necessary to obtain results of developmental screening. Case conferences involving the physician, worker, and staff of any other agencies involved with the family have been held as necessary to review cases of significant biological or environmental risk and to coordinate preventive interventions.

Approximately a year after the Leeward Healthy Start project began, a Federal Maternal and Child Health SPRANS (Special Projects of Regional and National Significance) grant funded "piggyback" efforts to enhance pediatricians' involvement with project families. The SPRANS effort was designed to increase pediatricians' awareness of the "new morbidity" and the needs of at-risk children. At the same time, the project educated families about the need for well care, in addition to episodic sick care, and helped them to use physicians' services more effectively.

The Medical Home Project now operates under the auspices of the Hawaii Medical Association. The effort has gained national recognition and a second grant, to further develop the concept of the medical home and to provide technical assistance in initiating similar projects throughout the United States.

5. Coordination of a range of health and social services for at risk families

Coordination of services is a major feature of the Healthy Start program. Because high risk families generally lack trust in people and services and thus do not reach out for help, those families who need service most are the least likely to seek them. As it reaches out to and builds trust with high risk families, Healthy Start is in a position to coordinate a wide range of services to families. The Healthy Start Model (figure 3) illustrates its approach to connecting families to the services most commonly available in communities.

6. Continuous follow-up with the family until the child reaches age five

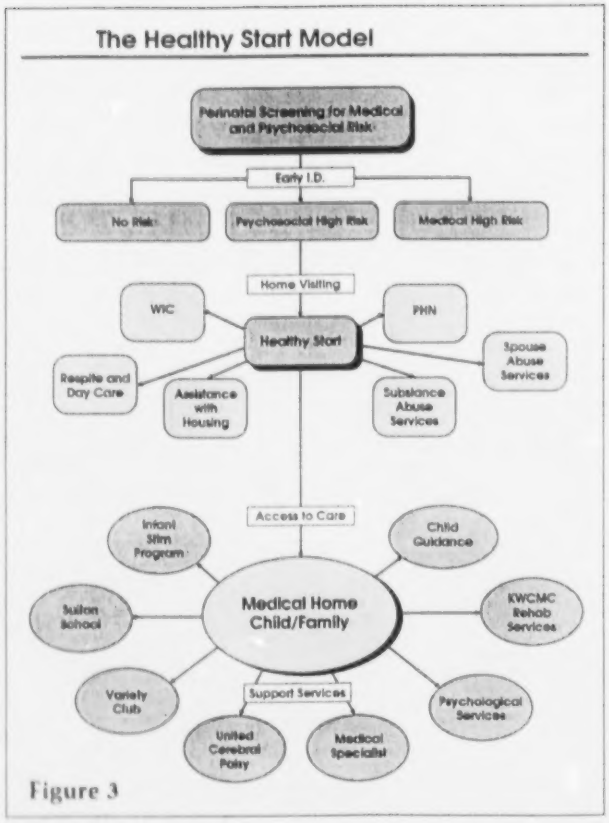

Figure 3

An earlier service program stopped following families once they were no longer considered "high risk." In a number of these families, cases of child abuse and neglect were reported later. Family situations can deteriorate, and the birth of subsequent children can add to family stress. Learning from our earlier experience, we designed the Healthy Start program to maintain follow-up until the target child reaches age five and enters school. At that point, the educational system provides at least some link between the family and the larger community.

7. A structured training program in the dynamics of abuse and neglect; early identification of families at risk; and home visiting

A standardized training program has allowed Healthy Start to share experience with new teams and establish uniform standards of service delivery as the program expands. All training is coordinated through the Healthy Start Training and Technical Assistance (HSTA) Team.

Training is provided in three phases. In Phase I, all new teams participate in a five-week orientation, which includes a core curriculum developed collaboratively by educators, human service providers, medical professionals, home visitors, and social service administrators. During the orientation, managers and supervisors, early identification workers, and home visitors receive training specific to their jobs. Trainees "shadow"

experienced workers and visit community resources. The training for early identification workers typically takes three days of specialized instruction plus several weeks of closely supervised work.

Four to six months after Phase I training, all staff attend a five-day advanced training session. This Phase II training reinforces key concepts and introduces additional concepts that workers would have been unlikely to absorb during the orientation.

After a team's first year of operation, it begins to participate in Phase III, or inservice training. Each team receives four half-days of inservice training per year at its own site, choosing topics from a menu of offerings distributed annually. This mechanism has been particularly useful for programs in remote areas of the state.

A fourth phase of training, "Health Start Supervisor Training," is being implemented this year, following the HSTA Training Team's participation in NCCIP's 1990-91 Training of Trainers Intensive Summer Seminar and follow-up program. This training focuses on the supervisor/home visitor relationship in its broadest sense.

Training for all phases is provided by the HSTA Team and by community consultants who have been identified as both experts in their field and very good presenters. We have found that including consultants has increased awareness of Healthy Start among other community agencies and the University, helping to enhance overall service coordination. The HSTA Team also provides regular technical assistance through visits to all Healthy Start sites, thus assuring standardized practice and clear communication among all teams statewide.

The Healthy Start Network, comprised of managers and supervisors from each team, meets each quarter for planning and program development. This mechanism has resulted in a close network with a shared mission, rather than seven agencies working in isolation.

8. Collaboration with the Hawaii Coordinating Council for Part H of P.L. 99-457 (now P.L. 101-476) to serve environmentally at risk children

The State of Hawaii has included children at environmental risk in its definitions of eligibility for services under Part H of P.L. 99-457 (now the IDEA, Individuals with Disabilities Education Act, P.L. 101-476). Healthy Start staff testified before the legislature as to the need for including environmentally at risk infants and toddlers and for funding care coordinators and a tracking system.

Currently, Healthy Start refers children with identified developmental delays to the local Zero to Three Project (Part H) care coordinator, who arranges with child development centers for early intervention. Healthy Start and Part H staff are working collaboratively to develop a format for the Individualized Family Service Plan.

The Zero to Three project has funded a child development specialist for the Leeward project, who will work with families needing special monitoring. Legislation is being proposed to add child development specialists to other Healthy Start staffs as well.

9. Staff selection and retention

Teams consist of 5-8 paraprofessional and supervisory staff, based on an agreed upon ratio. This ratio is 1:5 for supervisors and 1:3 for managers also carrying administrative responsibilities.

For managers, we look for masters level professionals who have both clinical experience with dysfunctional families and supervisory experience, preferably with paraprofessional staff. Selecting the right staff for each role is critical to both program effectiveness and staff retention.

We find that home visiting and early identification offer different job satisfactions, and applicants can usually tell which position would be more suited to them. EID workers like the sense of a task completed, while home visitors gain satisfaction from ongoing projects. In our interviews, we often use a sewing example: Some people like to sit down and finish a project, and hate to have it go over into another day. Others like to make quilts, a long-term, slow project. Home visitors are the quilt makers.

We look for similar personal qualities in both home visitors and EID workers—empathy, compassion, inner strength, high self-esteem, nonjudgmental attitudes, and status in their neighborhood or family as a natural helper. We have found that people who have experienced abuse themselves burn out more quickly than those who have had more nurturing childhoods; we ask prospective workers the same questions about their childhood experiences that new parents are asked during the EID interview.

Having hired good staff, we work to keep them. Staff members have identified several aspects of the program that are meaningful incentives to stay:

- Flexible hours (within reason), including time for family obligations like school conferences;
- An atmosphere of trust and caring through all levels of management;
- Tuition reimbursement for relevant continuing education;
- Emphasis on the significance of the project and the staff's contribution (including prompt feedback about all evaluation outcomes, linking these to outstanding staff performance);
- A system of salary increases that gives paraprofessional staff opportunity for advancement; regular raises are linked to demonstrated competence, experience, education and leadership qualities.

Evaluation of Healthy Start

We have a word of advice for anyone who hopes eventually to expand a model program: Invest in evaluation. Although the temptation to skimp on process and outcome evaluation in order to provide more direct services is ever-present, our advocacy

efforts would have been useless without impeccable evaluation data. Our evaluation provided the foundation for our advocacy. A good program, a strong evaluation, and collaborative advocacy were all essential in expansion toward a statewide system.

The Healthy Start demonstration project provided family support services to 241 high risk families. Of these, 176 had received services for at least one year at the time of outcome assessment at the end of the three-year demonstration. The outcome data reflected dramatic success in reaching our goal of identifying families at risk for abuse and neglect, and in preventing abuse and neglect in those families. A study of Child Protective Services (CPS) reports of confirmed abuse and neglect reports revealed:

- No cases of abuse of target children among project families;
- Only four cases of neglect (involving two percent of families) during the three year project, all reported by project staff to CPS;
- No abuse for 99.5% of all families identified by the initial hospital screening as not at risk.

Project staff identified a total of five infants as falling within the "imminent harm" category during hospital intake or later during service. Following Family Court Act provisions, staff referred the families to Child Protective Services; all families were followed by the project.[1]

Although clinical outcomes were not assessed with sufficiently stringent procedures to serve as indices of the project's effectiveness, there are indications of positive outcomes. Early Identification Workers who conducted initial risk assessments completed a second interview with families upon their graduation to Level IV. (Since these workers were not the families' home visitors, their assessments are less likely to be influenced by a close relationship.) Once "non-changeable" risk factors, such as parents' experiences of abuse in childhood or a history of CPS involvement, were eliminated from the analysis of pre and post scores, 88 percent of the 42 clients who were promoted to Level IV in the three years of the program showed a reduction of 40) 100 percent in their risk scores. The families who were promoted to Level IV also showed improvement on the NCAF and HOME scales, thus confirming the home visitors' judgments of their improved functioning.

In 1988 Craig Ramey and Donna Bryant of the Frank Porter Graham Child Development Center conducted an on-site evaluation of the overall program, contextual features, and process variables. They gave the project high marks in administrative organization, training and management of direct service staff, and quantity and quality of service delivery. They found "more esprit de corps among this group of home visitors than among any we have ever encountered, (with) no turnover (p. 28)." Ramey and Bryant described Healthy Start as a good example of cost-efficient public-private partnership, developed and administered by the private sector under purchase of service agreements with the state Maternal and Child Health Branch.

Data have just been analyzed for 1,204 at-risk families enrolled in expanded services state-wide during FY 1987-89. There was only one case of abuse (a 99.99% non-abuse rate), and six cases of neglect (a 99.95 non-neglect rate). In addition, there was no abuse or neglect among fourteen drug-exposed infants and six cases identified as "imminent harm" situations which were reported by the programs to protective services. These results are extremely exciting, as they prove the viability of effective replication of this program.

Statewide expansion

Expansion of Healthy Start toward a statewide system might best be described as an achievement of "collaborative advocacy." Our efforts go back to 1976 and our excitement about results from our first early identification and home visiting program. We started a Statewide Council on Child Abuse and Neglect, with representation from committees from five neighbor islands. Federal and state funds supported a prevention project on each island, but when the federal grant ended in 1980, staffing was cut by half.

We realized that we needed another demonstration project. In 1984, during the Hawaii Family Stress Center's annual lobbying for prevention before the state legislature, we met with Senator Yamasaki, Chairman of the Ways and Means Committee of the Hawaii State Senate. He saw merit in the idea of a demonstration program with comprehensive coverage of one geographic area, a focus on child development and linkage to a medical home, and follow-up to age five. He supported funding for Healthy Start at $200,000 a year, with the intent to expand statewide if the model were successful.

Armed with data showing no abuse among project children during the first 18 months of Healthy Start, we went back to the legislature for support for an incremental approach to statewide expansion. Through quarterly statewide meetings, we had maintained a relationship with the five neighbor island Family Support Programs. They and the two other agencies on Oahu with home visiting experience joined us to develop a statewide plan. Expansion of the Healthy Start model created no turf issues for the five Family Support Programs, since each served a distinct island community. On Oahu, home to 80 percent of Hawaii's population, there were turf issues to be resolved. The Hawaii Family Stress Center and the other home visiting agencies discussed the areas of Oahu that each was interested in serving. We also recognized that long-established programs did not have to adopt every detail of the Healthy Start model, as long as each program included essential features—i.e., intake at birth, creative and sustained outreach, and follow-up to age five.

The Stress Center developed projections and a budget for the expansion proposal, with agreement from the other agencies. We also developed good "visuals" for

our presentation to the legislature, such as a graph comparing the costs of courts and corrections, protective services and prevention services statewide. It is essential to have both impact data and data on the costs of not providing prevention services.

Figure 4.
Proposed Standards for Healthy Start/Family Support Programs

- Intake prenatally or at birth (2-3 months maximum age of infant at intake)
- Intake from defined target area (e.g., census tract) only
- Home visitor service for all infants from defined target area whose families are assessed as high risk by early identification workers, until maximum caseload capacity is reached
- Intensity of service based on needs of family
- Long-term home visitor service for all high risk families (3-5 years)
- Creative outreach approach for a minimum of 3 months to build client trust in accepting services
- Supervisory ratio of one professional to five paraprofessionals
- Defined worker caseloads (15 families in project year one; average of 20 families in year two; average of 25 families in year three)

For this legislative session, we worked with the Health Committee Chairmen of both the House and Senate to begin expansion of Healthy Start. We targeted our educational efforts first toward the chairs of the Health, Finance, and Human Services committees, and then to committee members. Our efforts to educate legislators about the prevention of child abuse had begun in 1976; some ten years later, our work seemed to begin to take hold. There were overnight changes in committee reports and behind-the-scenes maneuvers by at least one opponent of the program. The situation required careful watching, astute lobbying, and no end of patience. By the end of the legislative session, three new programs were funded.

Our major expansion effort came in 1989, after the data from the three-year demonstration project was available. We met with the whole Network and discussed how to prepare target group projections and budgets. Then each agency prepared its own program plans and budgets within the Network's agreed-upon guidelines (see figure 4). Each agency in the Network also participated in the lobbying/advocacy process and in ongoing program development. Our plan envisioned systematic screening and home visitor capacity sufficient to serve all at risk families identified in each geographic area of the state.

At this point, we needed more funding but did not require new authorizing legislation. Support for the Healthy Start model increased among legislators, with few suggestions for dilution. In our presentations to legislatures we try to make a few points very clearly:

- Healthy Start is designed to serve each geographic area comprehensively.
- Our model, in its entirety, is what produces the outcomes we see.
- Anything less will not get the results.

Figure 5.
Milestones in the Development of Healthy Start

1975	Small screening program; home visiting team of three workers
1976	Established State Council on Child Abuse and Neglect
1977-1980	Established five additional family support programs
1982	Renewed legislative advocacy
1985-88	Healthy Start demonstration project
1988	Expansion of Healthy Start to four additional sites; Healthy Start placed under Maternal Child Health Branch
1989	Expansion to total of 11 sites

Data projections and budget preparation are constant challenges. It is important to develop projections for each geographic area; among other things, this process allows us to show every state legislature what is needed to serve his constituency. We have developed a complex formula that takes into account the current number of births, projected growth in the birth rate, the number of families that projects can be expected to screen, and the number of families unlikely to accept services. To project a program's caseload over five years, we consider the number of newborns expected to enter the program annually, the number of families carried over from the previous year, and anticipated attrition. There will always be surprises. For example, the housing shortage has resulted in major shifts in the populations of low-income families.

A statewide program: Surviving and thriving

The situation of Healthy Start is unusual: The impetus for its establishment came from the private sector, but it is now institutionalized within the public sector. A statewide program must have a place within the established structure of state services in order to survive and thrive. Our program was placed in the mental health system from 1982-1988. The arrangement did not work well in our case, although it could conceivably work elsewhere. The Maternal Child Health Branch (MCHB), in contrast, has been a tremendous support to the development of Healthy Start as a statewide program. MCHB has provided a

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focus for coordination of all agencies, efficient contract management, monitoring, data collection, and advocacy for the program, both within the Department of Health and the larger community.

All members of the Healthy Start Network agree that the program needs to be completely statewide within a few years. Our current legislative effort is focusing upon providing existing programs with sufficient resources to maintain intake of newborns, which requires adding some staff each year, and to recruit and retain qualified staff. Next year or in the next biennium we will again pursue expansion, possibly bringing one or two new service agencies into our Network.

The issue of multiple sources of funding for a statewide program also deserves attention. It is a great deal to ask of a state legislature to fund a program as broadly based as Healthy Start from state revenues alone. Such a strategy would surely result in "dilution" eventually. Instead, we plan to use other funding sources as appropriate and available. For example, case management and potentially home visiting services are reimbursable under Medicaid. Part H may be able to reimburse us for development of Individualized Family Service Plans. We need to look also at the challenge grants within the National Center on Child Abuse and Neglect, which currently provides incentive matching to states through the Children's Trust Funds.

Healthy Start offers a systematic and highly effective approach to prevention of child abuse among the most vulnerable population—infants and toddlers at risk. It creates an excellent opportunity to focus on promotion of child health and development of these children. Moreover, it coordinates a range of services to the most needy families of a community.

In *Within Our Reach*, Lisbeth Schorr defined six challenges to efforts designed to prevent "rotten outcomes" of childhood. Healthy Start offers a solution for the challenges of knowing what works, proving we can afford it, attracting and training skilled and committed personnel, resisting the lure of dilution in replication, "gentling the hand" of bureaucracy, and devising replication strategies. Schorr further challenges programs to develop methods of linking populations at risk with needed services, clearly a major contribution of Healthy Start. We look forward to collaborating with colleagues to meet remaining challenges in accomplishing this most worthy goal, so that all of our children may have a safe and healthy start in life.

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Calls for Papers:

The World Association of Infant Psychiatry and Allied Disciplines (WAIPAD) is accepting submissions for its Fifth World Congress, entitled "A Future for Babies: Opportunities and Obstacles," to be held September 10-12, 1992 in Chicago, Illinois. Submissions are invited for symposia, workshops, clinical teach-ins, posters, and videotaped presentations on three themes: 1) psychological aspects of medical illness and technology; 2) infant-caregiver relationships; and 3) development and psychopathology. **All submissions must be received by August 1, 1991.** For submission forms and information about the Congress, write to Charles Zeanah, M.D., Women & Infants Hospital, 101 Dudley Street, Providence, RI 02905, or call Jo Sawyer, tel: (312) 621-0654.

The Literature Prize Committee of the **Margaret S. Mahler Psychiatric Research Foundation** is now accepting papers to be considered for the 1991 annual prize of $750, which will be awarded to the author of an original paper which deals with clinical, theoretical or research issues specifically related to Dr. Mahler's concepts of separation-individuation in child development. For more information contact Harold Blum, M.D., Acting Chairman, Margaret S. Mahler Literature Prize Committee, 23 The Hemlocks, Roslyn Estates, NY 11576.

Infant-Toddler Intervention, a new journal for early interventionists, invites manuscript submissions from early interventionists in all disciplines. Articles may be based upon empirical or clinical data and should be directly relevant to contemporary issues in early intervention. Manuscripts in APA style may be submitted in duplicate to Louis Rossetti, Ph.D., Editor, Infant-Toddler Intervention, Speech and Hearing Clinic, University of Wisconsin-Oshkosh, Oshkosh, WI 54901.

Replicating Demonstration Projects: A Beginner's Guide

by
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Responding to the plight of young children in America, social scientists, practitioners and grantmakers have used their resources to develop intervention programs to improve outcomes for children and their families. Designing and implementing effective intervention strategies constitute a significant challenge. But an even greater challenge may be the development of systems for replicating successful programs.

Because replication involves multi-year commitment of substantial funds, replication efforts have been supported traditionally by larger foundations or public institutions. Small to mid-size foundations have preferred to support demonstration models of intervention. Smaller grantmakers assume that a successful demonstration program will be able to attract replication monies; thus a modest investment of their foundation dollars could have a significant impact on practice, and ultimately on the lives of children in need.

The A.L. Mailman Family Foundation is a mid-size, private family foundation with a commitment to programs that strengthen families and enhance the development of children. A major focus of the Foundation has been the identification of intervention models with a high potential for demonstrating effectiveness. Demonstration programs have appealed to us for several reasons.

- First, small demonstrations, if successful, can have a major impact on the field through replication.
- Second, service-based demonstration programs are likely to have grassroots support; this makes them appealing to foundation trustees.
- Third, our support can help promising demonstration projects that face a "Catch-22" of grantmaking: large foundations will pass over such projects because they want to support major initiatives, and public funding sources will see them as too risky to support.

The A.L. Mailman Family Foundation has been successful in discovering and funding innovative intervention programs, some with impressive outcomes. However, our assumption that these programs would be automatically replicated turned out to be false. With the wisdom of hindsight, we recognized some of the problems with our demonstration/replication hypothesis.

- First, public money to support replication is difficult to secure.
- Second, pilot programs or demonstration projects, even when successful, can be costly to the originating organization. Such programs typically drain the energies of key personnel. And at the end of the demonstration period, the loss of personnel who were hired specifically for the pilot project but who have begun to make important contributions to the core agency, may leave the organization in a weakened position.
- Finally, the development of proposals for special projects diverts staff from seeking support for ongoing agency operations.

In evaluating our grantmaking, the Foundation policy committee decided to look more closely at the problem of replication. We wanted to understand: 1) the major programmatic obstacles to replication; 2) the critical features of a replicable model; and 3) the critical features of a replication site.

What are the major programmatic obstacles to replication?

Difficulties in replicating a model program can originate in the parent agency, the replicating agency or both. Problems associated with the parent agency almost inevitably involved a shortage of resources for the replication effort. The task of lending expertise to the replication effort very often taxed the strength of the parent organization. "Daughter" organizations, or replication sites, were also hampered by a lack of resources. Often the financial and human resources needed to bolster a fledgling program were not forthcoming because a sense of ownership for the "import" was missing, both at the agency level and in the community. There might be skepticism about an approach that had not been the brainstorm of the daughter agency itself: "It might have worked for the people out there, but it certainly won't work for us."

What are the critical features of a replicable model?

Identifying the obstacles to replication helped us to develop criteria for selecting a model likely to be replicated successfully.

- An obvious criterion is documentation of successful outcomes. Unless there is clear evidence that a demonstration program has achieved desired objectives in its original site, it is hard to justify replication.
- In order for a program to be transportable, the factors critical to its success should not be context-bound. A program that was effective for a particular geographic area, addressed a target population with unique characteristics, or owed success to a one-in-a-million charismatic leader might not be easy to transport.
- Some contextual supports do seem critical to the success of a demonstration program; these, then, must be available at the replication site. Such success factors are likely to include a strong, committed leadership; a well-established sponsoring agency with solid staff and good financial standing; community trust and support; and a sense of mission.

What are the critical features of a replication site?

The characteristics of an appropriate replication site are determined by features of both the original model

program itself and by the identified contextual supports that need to be transported.

- In order for a new site to buy into the objectives of the demonstration project, both "mother" and "daughter" agency or community must share similar problems, missions, and goals.
- The transportable core of success factors, whether they be leadership, facilities, or community support, must be present in the replication site.
- The replicating organization must have a secure self-image in order to maintain its own identity while adapting the new model.

While the problem of how to approach the replication issue was on the Foundation's front burner, serendipity assisted our efforts.

An opportunity for an experiment in replication

The Foundation was presented with an ideal opportunity to fund a replication project in 1988, when we were approached for support by the Parent Services Project (PSP) of California. The Parent Services Program is a parent-to-parent support model that uses child care centers as a base of operations. Based on the premise that healthy and stable parents can best nurture healthy, secure children, PSP was developed to improve parenting skills and to strengthen parents' ability to take charge of their own lives.

The original PSP sites in California were child care centers serving primarily low income families. The centers served diverse populations and offered a range of services, but all regarded parent/community involvement as a basic component of quality child development programs.

The PSP model, which was developed in the first sites and remains fairly constant from center to center, gives leadership training to parents and encourages parent control of services. Parents shape the PSP offerings at each site. These may include respite and sick child care, workshops on first aid, General Education Diploma and English as a Second Language classes, ethnic cooking or exercise classes, peer support groups, and workshops on stress reduction, sexuality or mental health. A parent services coordinator, usually a part-time staff person at each site, is responsible for the implementation of activities and programs.

Two especially popular features of the PSP model are family activities and celebrations and a parent-controlled fund to meet family emergencies. Many family activities and outings, always with meals or refreshments, occur throughout the year. There are also adults-only social events, with child care provided. The parent fund provides small amounts of money to help families in emergency situations. Equally important, the fund provides families with opportunities to share in a decision-making process.

An independent longitudinal evaluation of eight child care centers in the San Francisco Bay area, where PSP had been in place since 1980, found that the PSP approach had reduced parental stress and prevented symptom development among the low income parents of young children served by the program (Stein, A.R. and Haggard M., 1989).

Unquestionably, the Parent Services Project was an exciting model. As Foundation staff and trustees talked with Ethel Seiderman, PSP's Executive Director, we became convinced quickly that PSP was an ideal candidate for replication. The parent organization had the maturity of experience and the organizational base, including back up staff, to support a replication effort. Ethel Seiderman's personal interest and commitment would offer the necessary leadership.

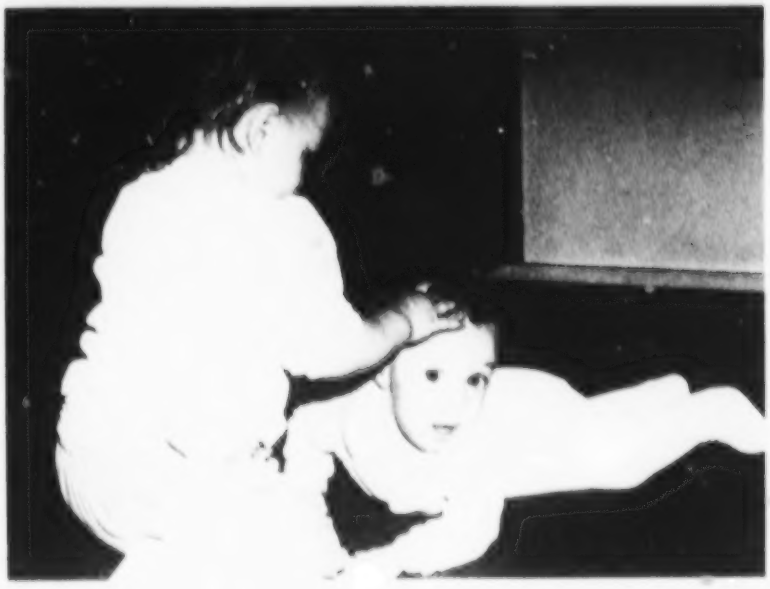
PSP's enthusiastic response to our request for a grant proposal brought the Foundation to the half-way mark. Our next challenge was to identify an equally promising "daughter" agency to serve as a replication site. Fortunately we were able to identify a strong comprehensive child care program, Child Care Connection (CCC), which was seeking to add a parent component to its child care centers. In 1988, CCC was providing subsidized child care services for more than 5,000 children in 38 centers and family day care homes in Broward County, Florida. Under the dynamic leadership of Barbara Weinstein, the agency also trains child care providers, offers resource and referral services, and provides a variety of other services for children and families. The Child Care Connection Board studied the PSP model and endorsed a plan to pilot the model in at least two child care centers serving low income families.

The replication process

The Parent Services Project and the Child Care Connection worked together to develop a proposal for funding to enable CCC to implement the PSP model in Broward County; the proposal was approved by the Foundation. The two agencies developed a training plan.

CCC used its grant funds to send four staff members for a five days of training in California. PSP used its grant to cover the costs of preparing and delivering the training. The training in California included presentations on the theoretical underpinnings of the PSP model; workshops on working with families, cultural awareness, governance and planning, budget, and developing private/public partnerships; and meetings with the PSP evaluators. The Florida team visited several PSP sites, meeting with staff and parents to learn about implementation issues directly from the people running the programs. In the final session, PSP and CCC staff reviewed what elements of the PSP model might or might not work in Florida, developed an action agenda, and made plans for follow-up training activities.

As the CCC team began implementation of the PSP model at two sites, PSP staff held twice-monthly telephone conferences with the CCC administrator and center directors. After six months, a second training was held in Florida, with the California team observing the new PSP sites and providing assistance as needed. Regular telephone conversations between the California and the Florida staff continued well beyond the first



SUBJECTS AND PREDICATES

year of replication. The costs of all of these activities were covered by the Foundation grants.

The Foundation also made a grant to Nova University for a process evaluation to record the implementation of the pilot in Florida. Developed in collaboration with PSP and CCC, the evaluation plan documented all aspects of the training and replication process.

Bases for rapport

It became clear very early in the grant period that PSP and CCC were ideally suited to work with each other. Both agencies endorsed the underlying premises of the family support philosophy, which emphasizes enhancing the capacity of families to support the well-being of their members. Both agencies shared an enthusiasm for the PSP model itself. The two agencies had similar experiences in administering substantial funds for publicly supported child care in their regions. They had similar strengths—staff skilled in training, strong leadership, and a sophisticated understanding of funding and political processes.

Camaraderie began to develop between PSP and CCC during the process of preparing CCC's grant proposal to the Foundation. The experience of joint decision-making encouraged reciprocity and lessened the likelihood of defensiveness about bringing an "outside" model to an established agency. The collaborative relationship between the CCC and PSP teams was strengthened by the welcoming attitude and training style of the California team. Visiting sites to see the PSP model in action during the training week in California helped the CCC team envision its potential for serving low-income families in Broward County.

The collaborative spirit has continued beyond the initial replication period. With modest support from the Foundation, both the California and Florida teams have made joint presentations at national professional conferences in 1989 and 1990.

Scope of the replication

Florida's PSP program began in August, 1988 in two child care centers serving a total of 160 families. Within 18 months, the program had expanded to four centers serving more than 400 families. Funding for the expansion of PSP in Broward County has come from the School Board, the Children's Services Board, private foundations, a community foundation, corporate support, and individual contributions. The A.L. Mailman Family Foundation provided second year support to sustain the replication of PSP at the two original Florida sites. The Foundation is also supporting the PSP Florida team to promote further replication in Florida, with the California team providing continuing assistance.

Under the leadership of Ethel Seiderman, PSP has moved energetically into training, using the model developed with CCC. The organization has secured training grants for work in and outside of California.

The role of the process evaluation

The process evaluation funded by the Foundation in tandem with its grants to the parent and replicating agencies provided ongoing feedback that helped to shape the replication process. The evaluation focused attention on the decisions made throughout the training and implementation phases, making the process more intentional and self-reflective for all participants. PSP used the evaluation conducted by Nova University and its own internal evaluation as tools for building a model for subsequent training projects.

Information from the process evaluation also helped to sustain the replicating agency through difficult periods. In several instances, the evaluation process alerted the replicating agency to the existence of a problem. When the daughter agency then discussed the issue with the parent group, the parent agency could use its own experience to place the problem in context. For example, when the Nova evaluation team reported that the parents in a Florida PSP center relied too heavily on child care staff for making programmatic decisions, the CCC group consulted immediately with the California team. The California team assured their Florida colleagues that over-reliance on staff was to be expected: Leadership skills take time to build; many of the PSP centers in California had experienced the same kind of parent reluctance. Reassured by this explanation, CCC staff were able to persist in their effort without losing patience or optimism.

Ingredients of a successful replication experience

While the PSP replication experiment was a unique effort undertaken in a unique set of circumstances, it nevertheless provided us with some fresh insights into critical features of a successful replication experience.

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1. The model should be both simple and exciting.

The simplicity of the model allowed it to be adapted easily to the unique needs of each center's group of parents, without impairing the integrity of a center's core program. At the same time the model was exciting — the parent agency was highly motivated to share it, and "converts" were easily recruited.

2. Flexibility is important.

Flexibility characterized not only the parent and replicating agencies but the funding agency as well. The Foundation had to recognize that replication is an unfolding process, which requires room for innovation along the way. Finally, the PSP model itself was characterized by a high degree of flexibility and adaptability, allowing it to conform to the needs of different settings and populations.

3. Attention must be paid to issues of ownership.

When both the parent and replicating agencies had to come to terms with issues of control and ownership, they did so with an underlying sense of respect and confidence in each other. The original California team was able to offer guidance without the need to control outcomes. The collaborative relationship that was established between the parent and daughter agencies early on allowed both teams to view everyone's contributions as important and valid, throughout the training and implementation process. By providing resources to both the parent and replicating agencies, the foundation was able to cement a partnership that empowered both parties and gave them the impetus to take on the risks of replication.

4. Continuity of investment is critical.

From the outset, all parties to the replication were committed to see the effort through to its completion. Both parent and replicating agencies had a sound financial base, a stable staff and excellent leadership. This security enabled them to consider the replication effort and undertake it, with the understanding that a long-term expenditure of resources would be involved. The Foundation recognized that it too had a commitment to sustain the experiment past its initial phase and continue to provide resources for the replication sites.

In major if somewhat unanticipated ways, the parent and daughter agencies have been shaped by the replication project. PSP of California has turned to training as a major agency activity. CCC is seeking ways to finance the PSP model as a core feature of programming for its child care centers.

5. Be patient.

It takes time to transplant any model into new settings and to nurture it through both good and lean times. We do not know how well second and third generation PSP projects will take root in Florida. We do not know how they will be sustained financially in the long term. What we do know is that the PSP model itself takes time to mature in a new setting and that it takes awhile before parents assume leadership of the program. In successful program replication, as in any parent/child relationship, the daughter agency must mature in order to be effective without the parent. And the parent agency must know when to let go and applaud from a distance.

National Center for Clinical Infant Programs
Seventh Biennial National Training Institute

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Watch for the first program announcement and registration form, to be mailed in May, or call, fax or write Sharon Godsey, NCCIP Conference Coordinator, EMC2, P.O. Box 7270, McLean, Virginia 22106-7270, tel: (703) 356-8301, fax: (703) 790-7237

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Managing Growth at Child Care Solutions

by

Ruth Anne Foote
Save the Children Child Care Support Center
Atlanta, Georgia

Child Care Resource and Referral (CCR&R) Services see themselves as a vital part of the country's child care system. Their rapid growth during the last decade has resulted in large part from the urgent demand for infant child care. When Child Care Solutions began to provide resource and referral services for 11 metropolitan Atlanta counties in 1983, 42.5 percent of the parents who called that year were seeking care for children under 12 months. In ensuing years, the percentage has remained fairly constant, ranging only from 36 to 42 percent. The parents who have called upon Child Care Solutions are often first-time users of child care. Their families have never turned to sources outside the family for infant care, and their employers' personnel policies have assumed that children were cared for by a non-working spouse. They have found little in their experience or their support structures to help them locate and select caregivers for their babies.

Child Care Resource and Referral Services can provide much needed support, not only to parents, but to all constituents of a child care system, including providers, employers and communities. In order to cope successfully with increasing demand, however, a CCR&R must manage its own growth carefully. This article describes several major principles for managing growth that have helped us at Child Care Solutions through the exhilarating process of coping with current demands, and gathering resources to meet new demands.

The growth of Solutions

Child Care Solutions began in 1983, a project of Save the Children's Child Care Support Center. For the first five years of its existence, Solutions was the only CCR&R offering referral to the general public in Georgia. Solutions began with a $5,000 grant from the Metropolitan Atlanta Community Foundation, a $3,000 grant from the Gannett Foundation, and three part-time staff members working a total of 33 hours per week. Fortunately, Solutions' parent agency, Save the Children, was willing to absorb significant administrative costs, and its own staff members were willing to double up on responsibilities in order to meet a pressing community need. The referral service listed 630 family day care providers in seven counties in its data base and offered referral to 2600 parents in its first year.

By 1990, Child Care Solutions employed 16 full time equivalent staff members and listed 1094 family day care providers, 643 centers, 257 school-age programs, and 96 half-day preschools in eleven counties in its data base. It offers referral to 8,000 parents each year. (All referrals are to providers registered with the Department of Human Resources, but referrals are not recommendations.)

Our range of services has widened as well. In addition to counseling parents, Solutions offers:

- a provider warm line, which offers technical assistance and information on registration and training to family day care providers;
- two family child care resource rooms in suburban counties;
- a consultant who assists churches and not-for-profit organizations in starting child care centers and programs for school-age children;
- a trainer who works with both centers and family day care providers; and
- an emergency child care specialist who assists families in crisis in resolving child care problems.

What is Child Care Resource and Referral?

Child Care Resource and Referral Services are a vital part of the country's child care system. They serve all the system's constituents.

- CCR&R offers referral, consumer education, problem solving, and information on child care to parents, usually through telephone consultations.
- CCR&R offers training, technical assistance and consultation to child care providers, much of it directed toward helping family day care providers and other child care programs get started and meet licensing or other standards.
- CCR&Rs work with employers to help them understand their employees' work and family conflicts and offer programs to relieve work/family stresses.
- CCR&Rs work with communities to help them plan for children's needs for care while parents work. The focus is on the collection of data on child care demand and supply, and advocacy to help communities develop affordable, accessible, quality child care.

Solutions manages contracts offering "enhanced referral" (vacancies are confirmed before parents are called back) and other employee assistance to 100 companies. Sister programs at Save the Children/Child Care Support Center offer payment for child care through vouchers, special assistance, and advocacy for quality child care in three low-income communities; provide advocacy and technical assistance on school-age child care issues; and offer special assistance and support to refugee families and family child care providers. Staff of Child Care Solutions has assisted in the organization and development of three new CCR&Rs in other parts of Georgia and is helping to develop two more services during 1991. We have joined

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with these five groups to organize a Child Care Resource and Referral network for Georgia.

How does a project manage growth like that? Our seven years of experience have taught us some principles that seem worth sharing.

1. If you expect rapid growth in a project, start with careful planning and get a good foundation before you begin to grow.

Save the Children/Child Care Support center staff spent several months in research and consultation with experts around the country before opening the referral service. We collected an extensive library of CCR&R materials from other agencies. We stated basic goals for the project, thought through procedures, and put policies in writing before collecting the database and beginning referrals. We developed plans for collecting and analyzing data.

Other CCR&Rs around the country were (and still are) generous with advice about what worked and what didn't. Solutions staff took the advice seriously and developed a service that reflected the best thinking of those experts. As a result, while we have done a great deal to fine-tune those early policies and procedures and to expand our scope, little has had to be undone and done over at the referral service itself.

Agreed-upon goals, well-thought-out procedures, and clearly stated, fully understood policies become more and more critical as demands for service increase.

This is a difficult principle to put into place retroactively. When an agency finds itself under great stress from high demand for service and only then recognizes that it lacks basic structures to deal with such demand, it is hard to stop and redesign structures. Especially if its manager is service-oriented and impatient with planning processes, an organization can become less and less effective. Sometimes an outside consultant can assist if work on basic structures must be undertaken in an ongoing operation. However, the people who are carrying out the day-to-day business of an agency are the people who know what needs to be done. They need to be the decision makers in this kind of process; the consultant is the facilitator.

Agreed-upon goals, well-thought-out procedures, and clearly stated, fully understood policies become more and more critical as demands for service increase. For example, we formulated a complaint policy, with procedures to follow in dealing with both parents and providers, before we opened our first referral line.

2. Manage demand to the extent that you can.

Child Care Solutions began small, with a plan to expand. During the first year of operation, Solutions referred to family day care providers only, adding other forms of care in subsequent years. Promotion of the service to users also began small; we notified other social service agencies of the service and placed classified ads in neighborhood newspapers. Later we sought greater exposure through advertising in the Yellow Pages; television and newspaper public service announcements; and press releases. These efforts never were a primary activity, since demand for referrals rapidly challenged our ability to respond, and has remained high.

Eighteen months after the project began, staff found themselves overwhelmed by parent demand. Parents experienced long delays in getting referrals, and counselors were spending valuable telephone time explaining to parents why they couldn't work any faster. This was an experience we were going to repeat in some form on other occasions.

A timely visit from Ethel McConagy and Fran Rogers of Work/Family Directions helped us to manage the crisis. They suggested that we turn our telephones off earlier in the day; we would thus limit callers to the number we could serve. We did this, using the moments of relief to take a look at our referral procedures and redesign them to be faster and more effective. We discovered that the numbers of parents we served did not go down, but staff stress was greatly reduced.

3. Growth in staff size is itself a crisis. It needs to be planned for and managed well.

One of Solutions' first service problems concerned how to maintain an equal opportunity referral service when requests from parents and providers conflicted with our policy. To deal with this issue, all members of the staff sat down together and hammered out a policy statement and procedures. The whole staff knew the policy and followed the procedures. Helping new staff (who were not at that meeting and do not even work directly with anyone who was there) to understand and implement the same policy is a task that requires more time and skill than developing the procedure in the first place.

As staff grows, good trainers of new staff and good supporting materials for that training are critical to maintaining a project's original quality and level of commitment. Project managers are often reluctant to let go of the task of orienting and training new employees, even though other demands on managers' time mean that orientation and training are slighted.

A gradual process of turning over responsibility for training to another staff member—eventually to more than one other person—often works. The manager may begin the orientation of new employees herself and then turn over parts of the training to experienced staff members. At the same time, she may designate a staff member to pull together training materials and procedures. Eventually, one of those staff members will have demonstrated the interest and ability to take full responsibility for training new employees. If she or he is given plenty of time to work on the project, careful attention, and increasing responsibility, she or he will develop in the job. Eventually even the most reluctant of managers will feel comfortable delegating responsibility for training of new staff.

Project managers can follow the same pattern in releasing and delegating other management functions which they at first feel uniquely qualified to undertake.

4. Think carefully about how you introduce change in a growing program.

The old card files and office set-ups that worked for a few part-time staffers become dysfunctional as a program grows. Managers begin to fantasize about computers and expanded space. New systems, however, may not solve existing problems as quickly as staff members would hope, and they frequently create new problems along the way.

The ability to function in crowded work spaces is not necessarily a sign of competence and strength of character.

Rearranging space: Urgent demands on space are common to growing, underfunded programs. Most of us who thrive on developing new programs assume that the ability to function in crowded work spaces is a sign of competence and strength of character. There comes a point, however, when congested work space impairs program function. Rearranging or expansion must begin. Child Care Solutions survived several rearrangements of space, with varying approaches and results.

Once, a few staff members remained behind in the evening and rearranged the office space without consulting other staffers. They achieved an efficient use of space, a quickly completed project, and a less than positive response from their unconsulted colleagues. On the other hand, we realized that rearrangement of space begun with a brainstorming session and working toward consensus would require more time and patience with group process than most of us were willing to invest. Staff reacted well to a process that involved key staff members developing alternative plans, inviting reaction and advice from users of the space, adapting the plan in light of the advice, and describing the rearrangement before it occurred.

Similar consultations with staff improve the quality and acceptability of changes in record keeping systems, work schedules, and other program structures.

Computers: When demands increase more rapidly than resources, most of us hope that computers will help us cope. But our CCR&R counselors had serious concerns about the possibility that computers might reduce the personal quality of their work. In order to make best use of what computers offer and keep the most personal quality of child care consultation and referral, adaptation is required of both counselors and computer systems. Solutions used computers gradually, beginning with storing data in one small personal computer and moving to a networked system with counselors doing intake and referral searches on line.

To make the transition work, we needed the help of computer experts who were willing to take the counselors seriously, counselors who were willing to change, and lots of time. Glitches and failures were a part of our transition. Counselors had to "check" computer systems by their old manual systems—some more times than others—before they really trusted the computer. We spent more time than we had expected, and confronted and solved more problems than we had imagined, before new computer systems became as effective as we had hoped. We retain a manual referral system to use for back-up when the computer system is down.

5. Flexible staffing patterns, and flexible staff, help agencies cope with growth.

From the beginning, Child Care Solutions has relied on counselors who work on the referral phones part-time. Some counselors are part-time workers; others are full-time employees who have other tasks in the agency and spend some time each week on the referral phones. The arrangement reduces burnout, since telephone referral is a demanding and repetitive task. It has enabled us to employ some excellent staff who wished to work part-time, including mothers of young children, graduate students, and retired professionals. Part-time telephone counseling also has allowed employees to carry out a variety of tasks and prove themselves adept at new skills before new positions opened in the growing project, giving us a good opportunity to train and promote from within. Maintaining and supervising a part-time staff increases demands on the supervisor, however; he or she becomes the primary communicator with an in-and-out staff.

The combination of program growth, the use of part-time staff, and promoting from within results in a staff which is often in transition. Flexibility is necessary in staff members who work in a rapidly growing program. For people who need a lot of control over their jobs, rapid growth may be more frustrating than invigorating. New programs and programs that expect rapid expansion need to look for workers who are flexible, creative, and face change confidently.

6. An established agency can help significantly to develop and stabilize a rapidly growing new program.

Much of Child Care Solutions' success and rapid growth can be credited to the fact that we are a part of a larger agency, Save the Children/Child Care Support Center, which has used its resources to develop and stabilize our program. Being part of a larger agency, whose purpose is to improve the lives of poor children by improving child care, has helped to develop and articulate the goals of Child Care Solutions. Child care resource and referral agencies' constituencies and funders are so diverse that direction and focus can be difficult to maintain. While we at Child Care Solutions continue to be challenged by growing demand and are eager to expand our role, our place within Save the Children clarifies our purpose—to help make quality child care available for Atlanta's working families, and especially for the poorest of those families.

Fulfilling that task and finding the resources to do so will continue to be a demanding venture.

National Center Notes

by Eleanor S. Szanton

This issue of *Zero to Three* documents what can be accomplished for infants, toddlers and their families when parents, practitioners, researchers, public policymakers and private foundations work in partnership. The National Center for Clinical Infant Programs is pleased to announce the beginning or expansion of several projects which should increase our ability to be helpful to those who fund, organize, staff and participate in services for our nation's youngest children.

• Under an interagency agreement between the Office of Human Development Services, Administration for Children Youth and Families, Head Start Bureau and the U.S. Public Health Service, Office of Disease Prevention and Health Promotion, the National Center for Clinical Infant Programs will be working to develop materials and training for Parent Child Centers (PCCs) within Head Start. Parent Child Centers provide comprehensive services, including social, health and education services, to low-income families with children under three years of age and to pregnant women. As a result of legislation enacted in the fall of 1990, the 37 current PCCs will be at least doubled in number this year; a specific focus for new grantees will be on pregnant women and infants.

• The Board of Directors of the David and Lucile Packard Foundation has awarded NCCIP a one-year grant, "Learning through Supervision and Mentorship," to promote the use of supervision and mentorship as key ingredients of preservice and inservice training of practitioners who work with infants, toddlers and their families. Supervision or mentorship was identified by NCCIP's Training Approaches to Skills and Knowledge (TASK) Project as crucial in helping both trainees and practitioners to translate conceptual and clinical knowledge into effective practice.

Drawing on the expertise of a multidisciplinary work group, the Learning through Supervision and Mentorship project will develop a document that discusses the rationale, overall function, and process of supervision and mentorship in infant/family services. The project will also suggest feasible mechanisms and strategies for improving supervision and mentorship at various levels of infant/family training and service. In addition, support for the continued publication of *TASKTalk*, NCCIP's bi-monthly newsletter for people involved in training infant/family practitioners and providers, will enable us to continue this valuable network.

• The Foundation for Child Development has awarded a grant to NCCIP that will enable our Better Care for the Babies Project (BCTB) to increase its technical assistance to states on the impact and implementation of the child care provisions of the Family Support Act (FSA—welfare reform). The BCTB Project is supported by multiple private foundations and corporate sponsors, with others in prospect, in its effort to help states access available expert knowledge and funding in order to improve early childhood services for disadvantaged infants and toddlers whose mothers may be affected by the Act. Concern about the particular challenges and opportunities presented by the Family Support Act is felt by state administrators, early childhood care and education practitioners, parents, and policy analysts alike. The Foundation for Child Development's leadership in monitoring the implementation of the Family Support Act, its support to BCTB for activity in this area, and BCTB staff participation in a Foundation-sponsored symposium on FSA illustrate the blending of expertise and resources that seem to characterize contemporary partnerships between foundations and grantees.

• We are also pleased to announce that the Center for Disease Control (CDC) has joined the public-private partnership of funders of BCTB's National Technical Assistance Forum, which will be held June 27-28 in Washington, D.C. The forum addresses the need for interagency planning and blended funding as means of improving the quality and scope of services provided to infants and toddlers throughout the child care system.

• NCCIP will be working together with Work/Family Directions to develop a curriculum to improve training for child care personnel—both center- and home-based—working with infants and toddlers. Supported by with funds from a number of corporations concerned about the quality of child care available to their work force, the curriculum will lead to training programs offering academic credit.

While NCCIP is growing, we remain dedicated to maintaining our unique focus on the earliest years of life. We also remain nourished by our roots—the practitioners, researchers, parents, educators and trainers, and policymakers who work to support the development of infants, toddlers and their families. We enjoy hearing from you, and we look forward to seeing you at our biennial "family reunion," NCCIP's Seventh National Training Institute, December 6-8, and at our newest gathering, the Better Care for the Babies National Technical Assistance Forum, June 27-28.

Publications:

The Unfinished Agenda: A New Vision for Child Development and Education (1991)—A Statement by the Research and Policy Committee of the Committee for Economic Development (Committee for Economic Development, 477 Madison Avenue, New York, NY 10022) $15.00, library binding; $12.50 paperback.

This new report from the Committee for Economic Development, the national business organization that published *Children in Need* in 1987, warns that ambitious education reform goals are destined to fail unless much more is done to meet the early health, social, and developmental needs of children, especially the disadvantaged. The report urges "a comprehensive and coordinated strategy for human investment that redefines education as a process that begins at birth and encompasses all aspects of children's early development, including their physical, social, emotional and cognitive growth."

The report urges combining a wide range of public and private resources to support a coordinated strategy of human investment. Some of the report's specific recommendations are:

- Programs for assisting children should also help strengthen the entire family.
- Every teen mother and father who has not finished high school should have access to a specialized school equipped to deal with the problems of teen parents and their children.
- Quality early childhood education should be available to all children who may not otherwise get adequate preparation for formal education from their families.
- Programs that address the needs of children and families must be flexible in design, administration and funding.
- Successful programs must be broadly replicated so that they are both more available and more accessible to all children in need and their families.

Child Care Choices: Balancing the Needs of Children, Families and Society (1991)—Edward F. Zigler and Mary E. Lang (The Free Press, 866 Third Avenue, New York, NY 10022) $22.95.

A national child care policy, the authors of this volume believe, "must provide all parents with genuine options ... they must have the freedom to choose the type of caregiving they want for their child, and they must have freedom to enter a child care system of universal quality." Families have primary responsibility for raising their children, but the total environment in which children develop is determined by institutions outside the family as well. Zigler and Lang call for making the "mixed system" of child care in the United States an effective social institution that supports families in fulfilling their childrearing as well as their work responsibilities.

While they discuss child care as a support to families with children of varying ages and needs, Zigler and Lang pay special attention to the caregiving needs of infants and toddlers. Zigler has long believed that very young infants need to remain at home with a parent

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to begin the process of forming a strong relationship. The developmental needs of older infants and toddlers can be met in a variety of caregiving environments, but quality child care, including individualized attention by well-trained staff, is expensive.

Zigler and Lang propose that the United States establish a child allowance trust fund as a means of assisting parents to care for their very young children with whatever combination of parental and supplementary care best suits their circumstances. The trust fund would expand the social security system to provide an annual stipend to all families for each of their children from birth to age three. The stipend could be used to help defray the cost of child care or as partial replacement income for parents who choose to care for their infants and toddlers at home. The authors describe the experience of other countries with child allowances and the fiscal and political issues that would need to be addressed here.

Psychosocial Issues in Day Care (1990)—Shahla S. Chehrazi, editor (American Psychiatric Press, Inc., 1400 K Street, N.W., Washington, DC 20005) $38.00 plus $5.00 shipping and handling.

The twenty contributors to this volume address a range of child care issues, including developmental considerations and day care; the relationship between parents and child care providers; pediatric issues; child abuse; and national policy. Several writers offer a mental health perspective on the experiences of young children, families, and providers in day care.

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Discussing children's responses to separation, for example, Barbara Kalmanson notes that "separation is a natural, recurring phenomenon that requires continuous emotional work throughout life." She suggests that day care providers can assist children in adjusting to substitute care by helping parents provide a gradual transition to day care and by offering the child many opportunities to master the experience of separation through play and through the relationship with the primary caregiver.

Alicia Lieberman notes: "Out-of-home care may elicit a heavier than optimal anxiety reaction in children, but the unavoidable experience of anxiety can be used as an opportunity for psychological growth when managed with patience and sensitivity by the important people in the child's life ... The clinician (can) serve as an ally to the child and to the parents in trying to prevent avoidable anxiety-arousing situations and in helping them to cope as adaptively as possible with those situations they cannot avoid."

Contributors to the volume include Susan Aronson, Jay Belsky, Shahla Chehrazi, Carolee Howes, Hon. George Miller, Patricia Nachman, Deborah Phillips, Marcy Whitebook and Edward Zigler, among others.

A Parent's Guide: Accessing Programs for Infants, Toddlers and Preschoolers with Disabilities (Update September, 1990)—National Information Center for Children and Youth with Handicaps (P.O. Box 1492, Washington, D.C. 20013, tel: 1/800-893-8614) Free of charge.

This 20-page booklet offers information about early intervention services in question and answer format; provides a parents' dictionary of terms used in special education; summarizes P.L. 99-142 and P.L. 99-457; lists books and other printed materials for families; and includes a sample record-keeping workshop for contacts with resources. The National Information Center for Children and Youth with Handicaps (NICHCY) develops parents' guides on an ongoing basis; recently published guides address doctors, disabilities and the family (May, 1990) and planning a move when a child has special needs.

Families as Nurturing Systems: Support Across the Life Span—Prevention in Human Services, Volume 9, Number 1 (1990)—Donald G. Unger and Douglas R. Powell, guest editors (The Haworth Press, 10 Alice Street, Binghamton, NY 13904-1580) $29.95 plus $2.75 postage and handling for single issue, $36.00 per volume per year.

Most of the authors contributing to this volume advocate supporting families through family resource programs that are aimed as much at family self determination as at addressing family needs themselves. The ecological perspective on individual-family-community-society interactions that informs the family resource movement suggests the need for "dramatic changes" in the ethos of professions and institutions serving families. For example, Eleanor Szanton's identification of the factors influencing partnerships between parents and professionals interested in children with special needs illustrates the tensions typically inherent in such relationships. Proposed remedies, such training by parents for professionals or increased parental involvement in decisionmaking, may themselves seem revolutionary.

Several essays in the volume contribute to the process of conceptualizing the family resource movement. Dunst, Trivette, and Thompson, for example, describe the differences in the assumptions of treatment, prevention and promotion models. They suggest that family resource programs adopt promotion models to strengthen positive functioning, rather than strategies designed simply to prevent negative outcomes.

SSI: New Opportunities for Children with Disabilities (1991)—Joseph Manes and Lee Carty (Mental Health Law Project, 1101 Fifteenth Street, N.W., Suite 1212, Washington, D.C. 20005, tel: (202) 467-5730) $3 each for 1-4 copies, with reduced prices for larger orders. Camera-ready artwork and print files on diskette are available to organizations wishing to distribute free copies.

This 12-page pamphlet is designed to answer parents' and advocates' questions about the new eligibility rules for Supplemental Security Income (SSI). Using question and answer format, the booklet describes the cash benefits and free health services available to children with disabilities in families with limited means. It discusses financial eligibility, determining disability, and applications and appeals. **SSI** advises readers:

> Until recently unfair and unrealistic rules kept many families from getting SSI and Medicaid for their children who have disabilities. The social services workers who assist them often became so discouraged they stopped telling families with children who might be eligible to apply.
>
> Reforms in the program should change all that. Now parents should aggressively press their children's applications for SSI. And if they applied before and were turned down, they may now be able to get benefits back to the time they first applied.

Children's Issues: A Decade of GAO Reports and Recent Activities (September, 1990)—Linda G. Morra (U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20877) First five copies of each GAO report free of charge.

Responding to a request from the Select Committee on Children, Youth and Families, staff of the U.S. General Accounting Office have compiled a listing of more than 250 reports, testimonies, ongoing assignments, and other issues affecting children completed since 1980. GAO's work has addressed issues of child day care, child welfare and social services, education, health, housing, income security, nutrition, youth employment and training, and other child and family issues. The bibliography listing the 58 reports issued from October, 1988 through March, 1990 is an annotated one. One learns, for example, that the GAO has studied not only government funding sources for child care, but also that the combined enrollment of Senate and House of Representatives child care centers was about 115 children in 1989.

In recent months, the GAO has issued additional reports concerning children and families: **Drug-exposed Infants: A Generation at Risk** (June, 1990); **Home Visiting: A Promising Early Intervention Strategy for At-Risk Families** (July, 1990); and **Respite Care: An Overview of Federal, Selected State, and Private Programs** (September, 1990).

Children and Parental Illicit Drug Use: Research, Clinical, and Policy Issues—Summary of a Workshop (1991)—Sarah S. Brown, Editor (National Forum on the Future of Children and Families, National Research Council, Institute of Medicine, 2101 Constitution Avenue, NW, Washington, DC 20418) Free of charge.

This 24-page document synthesizes the presentations and discussions of a March, 1990 conference on children and parental illicit drug use convened by the National Forum on the Future of Children and Families, which was established in 1987 to promote an ongoing dialogue in a neutral setting among scholars and experts in children and family issues and leaders in government, business, philanthropy and the media.

Reviewing the social and public policy context shaping discussions about research and treatment for parents—especially women—who use illegal drugs, conference participants noted that in many areas of the country policy is being developed by the courts, not the human services or health care system. Several participants noted unwillingness among policymakers to see the problem as just one example of the nations's "failed health and social services system."

A number of participants described intervention programs underway in their own institutions that they believed are helpful to the women enrolled, and the attributes of these programs. They include aggressive outreach, immediate admission to treatment, integrated services that include treatment of depression and family planning, attention to the whole family, and careful follow-up.

The report includes a summary of federal support for research on parental drug abuse.

Separate Lives: Why Siblings Are So Different (1990)—Judy Dunn and Robert Plomin (Basic Books, 10 East 53rd Street, New York, NY 10022-5299) $19.95.

One thing is clear, announce Judy Dunn and Robert Plomin: siblings growing up in the same family are very different. Research findings document vast physical as well as psychological differences between siblings in the same family and reveal that nongenetic factors—i.e., *nonshared* influences from the environment—must be primarily responsible for these differences. Factors that constitute the nonshared environment of siblings include differential parent-child relationships, differential experiences within the sibling relationship, influences beyond the family, and chance. To understand the origins of individual differences among siblings, one must ask about the extent to which a particular outcome is affected by each of these domains, by the many components within each domain, and by combinations of them. Furthermore, one-to-one associations are unlikely, and perceptions of events and of relationships are likely to be of major significance.

Dunn and Plomin suggest that the strong message about the importance of nongenetic differences on development should revitalize research on environmental influences that has been "overtaken by the sleek new high-tech vehicles of biology," especially in the area of mental illness. They also outline promising directions for developmental research in a variety of theoretical frameworks, and for systematic clinical investigation.

Mammalian Parenting: Biochemical, Neurobiological, and Behavioral Determinants (1990)—Norman A. Krasnegor and Robert S. Bridges, editors (Oxford University Press, 200 Madison Avenue, New York, NY 10157-0913) $75.00.

Parenting can be seen as one of the most important characteristic defining features of mammals; recent research has begun to elucidate the biological bases of this behavioral repertoire. The 22 chapters in this volume explore caregiving in mammals as an evolutionary strategy; the relationship between hormones and caregiving behavior; the relationship between central nervous system structure and parenting behavior; sensory factors involved in initiating maternal behavior; and the role of experience. The editors note that while animal studies now provide an understanding of those factors that regulate parental behavior in other mammals, the study of the biological bases of human parental behavior is in its infancy. They suggest that the research challenge for the next decade is to determine the extent of involvement of biological factors in the regulation of parenting in humans, and the way these factors interact during development with experiential and genetic events to shape the responsiveness of mothers and fathers toward their children.

Ways and Means for Children and Families (1991)—Carolyn Grose and John E. Kyle, editors (Publications Department, National League of Cities, 1301 Pennsylvania Avenue, N.W., Washington, D.C. 20004) $35 plus $2 postage and handling.

This volume is one of the National League of Cities' "Local Officials Guide" series, designed to assist local government leaders in carrying out their responsibilities more effectively. The editors suggest that cities are assuming an increasingly central role in coordinating and providing services for children and families. However, local government officials are frustrated by a real lack of funds on the local level and by a lack of commitment from other levels of government to address child and family problems.

The publication examines federal programs, state sources of support, and private funding for local programs affecting children and families. It gives examples of cities that have tapped these resources, lists funding agency contacts, and includes a step-by-step guide to writing a grant proposl. The publication also suggests that cities can improve child and family services without spending money, through regulations and leadership.

Conference Call:

May, 1991

May 17: The *Maine Association for Infant Mental Health, Inc.* will hold its Fourth Annual Conference in Portland, Maine. Susan Partridge will deliver the keynote address. The conference will also feature workshops on practical applications of infant mental health principles and facilitated interdisciplinary discussion groups. Write to Maine Association for Infant Mental Health, Inc., R.R. #1, Box 3350, Lubec, ME 04652.

May 26-29: The *Association for the Care of Children's Health* will hold its 26th annual conference in Minneapolis, Minnesota, with the theme "Our Changing Society: The Challenges of Caring in the 1990's." Speakers will include Marion Dewar, Arthur Caplan, Joyce Thomas, James Blackman, Mary Boland, David Jones, Christine Lubinsky, Patrick McGrath, Stephen Nicholas, Nancy Woods, and Kathleen VandenBerg. The Child Life Council Annual Meeting and the ACCH Parent Network Meeting will precede the conference. For information, write to ACCH, 7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814-3015.

June, 1991

June 1: The *Child Development Center at Children's Hospital Oakland* will sponsor a conference in Oakland, California entitled "Special Children: Pediatric Perspectives in the 90's." Faculty will include Jack Shonkoff (special guest faculty), Marshall Klaus, Barbara Ivins, Nancy Sweet, Richard Umansky, and Kathy Vandenberg, among others. For information, contact Kim Leadon, Continuing Medical Education, Children's Hospital Oakland, 747-52nd Street, Oakland, CA 94609, tel: (415) 3021.

June 9-13: *NAACOG*, the Organization for Obstetric, Gynecologic, and Neonatal Nurses, will hold its eighth national meeting in Orlando, Florida. Plenary speakers will include Rae Grad, Ira Chasnoff, Angela Barron McBride, and Charles Inlander, among others. Contact NAACOG, 409 12th Street, S.W., Washington, DC 20024-2191, tel: (202) 638-0026.

June 17-18: The *Ohio Department of Health, Ohio State University College of Medicine*, and *Children's Hospital*, Columbus, Ohio will sponsor a combined institute, "The 'New' Title V," in Columbus, Ohio. This is a repeat of the Institute offered in October, 1990. Contact Antoinette P. Eaton, M.D. or Tammy Perakis Wallace, Children's Hosptial, 700 Children's Drive, Columbus, OH 43205, tel: (614) 461-2511.

June 19-20: The *University of Nebraska-Lincoln, Departments of Sociology and Human Development and Center on Children, Families and the Law; the National Council on Family Relations;* and the *Woods Charitable Fund* will sponsor a national symposium in Lincoln, Nebraska entitled "Child Care in the 1990s: Trends and Consequences." Lead speakers will include Sandra Hofferth, Alison Clarke-Stewart, Karen Oppenheim Mason, and Phillip Robins. For information, write to National Symposium on Child Care, Department of Sociology, 711 Oldfather Hall, University of Nebraska-Lincoln, Lincoln, NE 68588-0324.

June 24-July 26: *Children's Hospital Medical Center of Akron's Family Child Learning Center* will sponsor its third annual summer workshop program in Cape May, New Jersey. Brief intensive courses, hands-on learning experiences, and interrelated workshops will be offered. Instructors are Philippa Campbell, Leslie Faye Davis, Winnie Dunn, Rebecca Fewell, Sarah Forsyth, Catherine LaForme, Gregory LaForme, Toby Long, Joan Lydic-Mettler, Lorraine McCune, Judy Pokorni, Barry Prizant, Jerry Staller, Kathleen Stremel, and M. Jeanne Wilcox. Contact Joan Markowski, Family Child Learning Center, 90 West Overdale Drive, Tallmadge, OH 44278, tel: (216) 633-2055.

June 26-28: The *Bank Street College of Education* will hold its fourth annual Infancy Institute in New York City, with the theme "Infants, Toddlers, Parents: Supporting Their Growth." G. Gordon Williamson will give the keynote address, and Anita Olds will give a special presentation on designing innovative physical settings. Write or call Dr. Nancy Balaban or Dr. Virginia Casper, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 222-6700, x 410 or x 335.

June 26-29: The *Fourth Annual Convention* of the Society for Disability Studies will be held in Oakland, California. The society is dedicated to the development and application of disability-related theory. For information, contact Irving K. Zola, Department of Sociology, Brandeis University, Waltham, MA 02254-9110, tel: (617) 736-2644.

June 27-28: The *National Center for Clinical Infant Programs* will hold its first National Technical Assistance Forum on Infant Child Care and Head Start Services in Washington, D.C. Entitled "Finding and Funding Quality," the forum will focus on state-level policy development; the coordination of Head Start and child care with health and early intervention services; and funding sources for infant child care and Head Start services. Featured speakers include T. Berry Brazelton, Sharon Lynn Kagan, J. Ronald Lally, Phyllis Stubbs, Eleanor Szanton, Bernice Weissbourd, and Edward Zigler. Space is limited; priority will be given to state agency administrators, Head Start program administrators, and administrators of large community-based child care programs funded by Title XX (Social Services Block Grant) and/or the Family Suppport Act (FSA). For more information, write or call Deane Argenta, NCCIP, 2000 14th Street North, Suite 380, Arlington, VA 22201, tel: (703) 528-4300.

July, 1991

July 1-4: The *Third International Workshop on the At-Risk Infant* will take place in Tel Aviv, Israel. The topic will be "The Developmental Neurobiological Basis for Early

Intervention: Animal Models and Human Data—Guidelines for Practice." Speakers will include William Greenough, Samuel Meisels, Emmy Werner, Tiffany Field, Nicholas Anastasiow, Shaul Harel, Esther Dromi, and Jack P. Shonkoff, among others. For information, contact International Ltd., P.O. Box 29313, 61292 Tel Aviv, Israel, tel: 972-3-654548, Fax: 972-3-660604.

July 3-7: The *International Society for the Study of Behavioral Development* will hold its eleventh biennial meeting in Minneapolis, Minnesota. Scientists from Germany, Australia, Sweden, Brazil, China, Poland, and the United States will deliver keynote addesses. A two-day preconference workshop on the assessment of early attachment relationships will be held July 2-3. Contact ISSBD, Institute of Child Development, 51 E. River Road, University of Minnesota, Minneapolis, MN 55455-0345.

July 8-19: The *George Washington University, Department of Teacher Preparation and Special Education, The Early Intervention Programs,* will present their ninth annual Summer Institutes in Early Intervention. Edward Feinberg will lead Ethical Considerations in Early Intervention, July 8-12. Mary Elder, Jerry Elder, Patricia Place, Carol Berman, and Susan Mackey-Andrews will be faculty for the Early Childhood Leadership Symposium, July 15-19. Contact Dr. Maxine Freund, tel: (202) 994-1547 or Dr. Carole Brown, tel: (202) 994-7328.

July 15-16: *Wayne State University, Merrill-Palmer Institute* will sponsor a Graduate Certificate Program in Infant Mental Health Summer Institute at Northwestern Michigan College in Traverse City, Michigan. Courses in the psychology of infant behavior, special issues in infant mental health, and infant mental mental health intervention will be offered. Call Deborah Weatherston, Merrill-Palmer Institute, (313) 577-6654.

July 31-August 1: *Project Sunrise* will sponsor its fifth annual Summer Training Institute on Hilton Head Island, South Carolina, with the theme "Training for Excellence: Bringing Visions of Quality to Center-based Programs." Speakers will include Kathleen Stremel, Victoria Rab, Toni Linder, and Linda Frederick, among others. Call or write Susan Bennett, Project SUNRISE, Western Carolina Center, 300 Enola Rd., Morganton, NC 28655, tel: (704) 433-2865.

August, 1991

August 1-4: The *National Association for Family Day Care* will hold its fifth national conference in New York City, with the theme "Family Day Care: The Core of the Big Apple—Nurturing the Seeds." For information, contact NAFDC, 725 25th Street, N.W., #505, Washington, DC 20005, tel: (202) 347-3356.

August 5-9: *Child Development Resources* will hold its Sixth Annual Early Intervention Summer Institute, co-sponsored by the College of William and Mary, School of Education, in Williamsburg, Virginia, with the theme "Changing Programs, Changing Roles: Coping with Change in the 90's." Faculty include Larry Edelman, Corinne Garland, Donald Kates, Roxane Kaufmann, Mary McGonigel, and Robin McWilliam. Write or call Lisa McKean, Institute Coordinator, Early Intervention Summer Institute, Child Development Resources, P.O. Box 299, Lightfoot, VA 23090, tel: (804) 565-0303.

August 20-23: The *Infant-Parent Institute* will offer its eleventh annual Brief Course in Infant Mental Health in Champaign, Illinois. Principal instructor will be Michael Trout, Director of the Institute. Write or call Mr. Trout at The Infant-Parent Institute, 328 North Neil, Champaign, IL 61820, tel: (217) 352-4060.

August 23-25: *The National Center on Parent Directed Family Resource Centers* will hold a symposium on "Creating a Collaborative, Family-Centered, Community-based Resource Center" at Santa Clara University, Santa Clara, CA. For information, contact Karen Grossman, PHP—The Special Children's Family Resource Center, 535 Race Street, Suite 220, San Jose, CA 95126, tel: (408) 288-5010.

September, 1991

September 26-29: The *Healthy Mothers, Healthy Babies Coalition* will hold a national meeting in Washington, D.C. For information contact the HM,HB National Office, 409 12th Street S.W., Washington, DC 20024-2188, tel: (202) 863-2458.

October, 1991

October 4-5: The *Institute for Pediatric Service of Johnson and Johnson Consumer Products Company, Inc.* and the *American Academy of Pediatrics* will sponsor a symposium in Arlington, Virginia on Day Care for Children. Faculty members are Susan Aranson, T. Berry Brazelton, Sue Bredekamp, Audrey Brown, Bettye Caldwell, Eileen Donahoe, John Donahoe, Rebecca Fewell, Ellen Galinsky, Scott Giebink, Ruth Gross, Margaret Heagerty, Phillip Hwang, Sheila Kamerman, Samuel Katz, Joan Lombardi, Elizabeth McAnarney, James McKay, Hubert Montagner, Antonia Novello, Jeree Pawl, Sandra Scarr, Hon. Pat Schroeder, Michelle Seligson, Esther Wender, and Edward Zigler. For information, write to Audrey K. Brown, M.D., Chairman, Board of Trustees, Institute for Pediatric Service of Johnson & Johnson Consumer Products, Inc., Grandview Road, Skillman, NJ 08858.

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